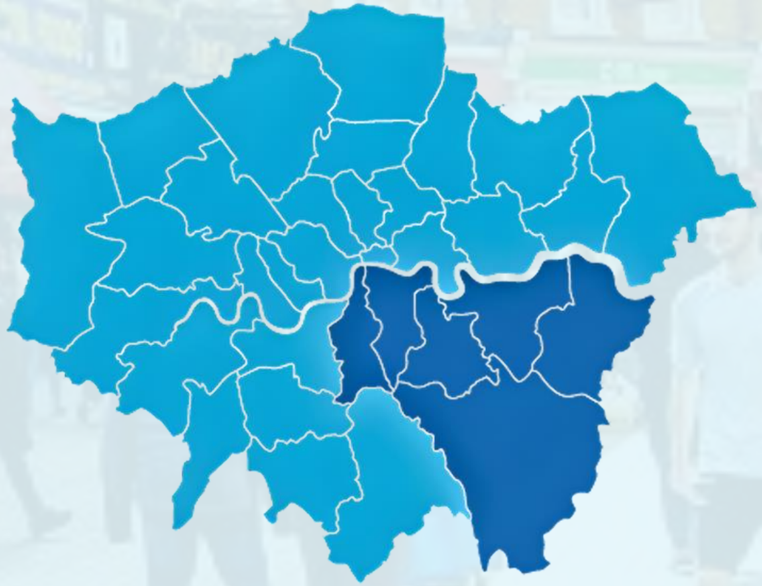
KING'S HEALTH PARTNERS

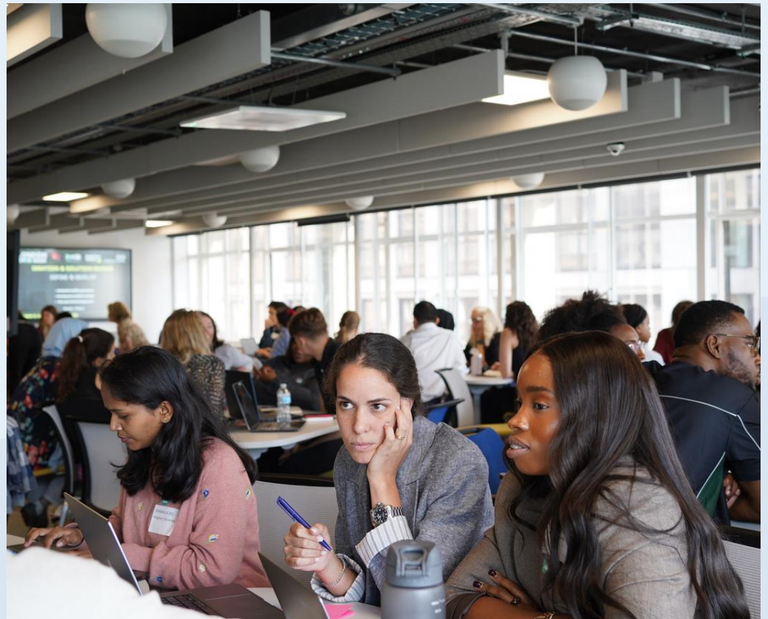
South East London Integrated Care System

South East London Prevention Framework

Supporting healthier communities



Contents



Executive summary

South East London (SEL) faces a growing health crisis. Life expectancy gaps of up to nine years separate the most and least deprived areas (1). Residents are falling ill earlier with preventable long-term conditions and dying younger from avoidable causes. These challenges are compounded by an ageing population and rising complexity of health needs among children and young people.

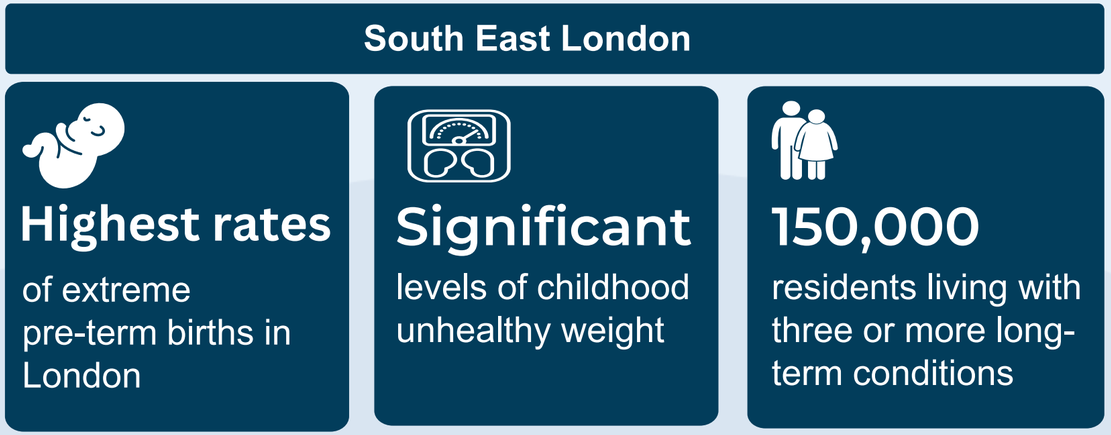
Currently, prevention accounts for only about 5% of NHS spending, yet evidence shows that early intervention could reduce ill health by up to 33% (2) . Investing in prevention isn't just good policy, it's essential for building a healthier population and easing pressure on the health and care system which in turn ensures we are making best use of our resources not just financial but people and planet. Yet progress is hindered by a lack of clarity around the definition of prevention, misalignment with routine government priorities, and limited capacity to reallocate resources.

To address this, integrated care system partners must shift resources from acute care towards effective interventions for all ages, delivered closer to home in the community. Prevention is about enabling people to be healthy and thrive for as long as possible. It focuses on addressing issues before they arise, prioritising wellbeing rather than simply treating illness. It ensures timely and effective care, equipping individuals with the knowledge and confidence to make informed choices about their health.

Existing efforts are not doing enough to benefit those most at risk of health inequity, deliver population-level health improvements or support system sustainability in the longer-term.

The **Prevention Framework** has been developed to enable SEL ICS to shift to being a prevention focused system that: supports and embeds prevention as business-as-usual; takes an evidence, data and insights informed approach to invest in interventions that have the greatest potential for population impact and return on investment; and optimises resources around prevention in support of future system sustainability.

The SEL Prevention Framework aligns with the ambitions set out in the NHS 10 Year Health Plan and London-wide commitments to improve the cardiovascular health of one million Londoners through London Million Hearts and Minds.



Health Index for South East London, Ethica Health Partners, 2025 (3)

SEL Prevention Framework

Our Prevention Framework is grounded by SEL ICS's long-term ambitions, and vision for prevention, wellbeing and equity. It has four aims and will be delivered through a prevention focused system across key prevention drivers, reflecting principles for high-value care.

Long-term ambitions

- Reduce the inequality gap in healthy life expectancy
- Ensure a good start in life and reduce child health inequalities
- Build trust in preventative services
- Reduce preventable deaths due to infectious and chronic diseases
- Reduce gap between mental and physical health outcomes

Vision

Ensuring people remain in **the best health they can be** for as long as possible, reducing disparities in healthy life expectancy

Aims

- Embed prevention as 'business-as-usual' across our system.
- Implement an evidence, data and insight informed SEL prevention offer that will deliver population-level impact at scale and reduce health inequalities.
- Optimise resources around prevention and invest in interventions with the greatest opportunity for ROI to support future system sustainability

Prevention drivers

Prevention focused system

- Wider determinants of health
- The places and communities where we live
- Integrated and equitable health and care system
- Healthy behaviours and lifestyles

Principles

- Community-led and clinically informed
- Holistic health and wellbeing approach
- Proactive outreach to underserved groups
- Consistent and targeted offer
- Cross-system collaboration
- Lever for better maternal and CYP outcomes

Our roadmap

Throughout 2025 SEL ICS brought together stakeholders from the NHS, local authorities, VCSE, and academic institutions for a series of workshops. These workshops fostered consensus on prevention priorities guided by data, lived experience insights, academic evidence, and the strategic direction of the SEL ICS Prevention, Wellbeing and Equity Board.

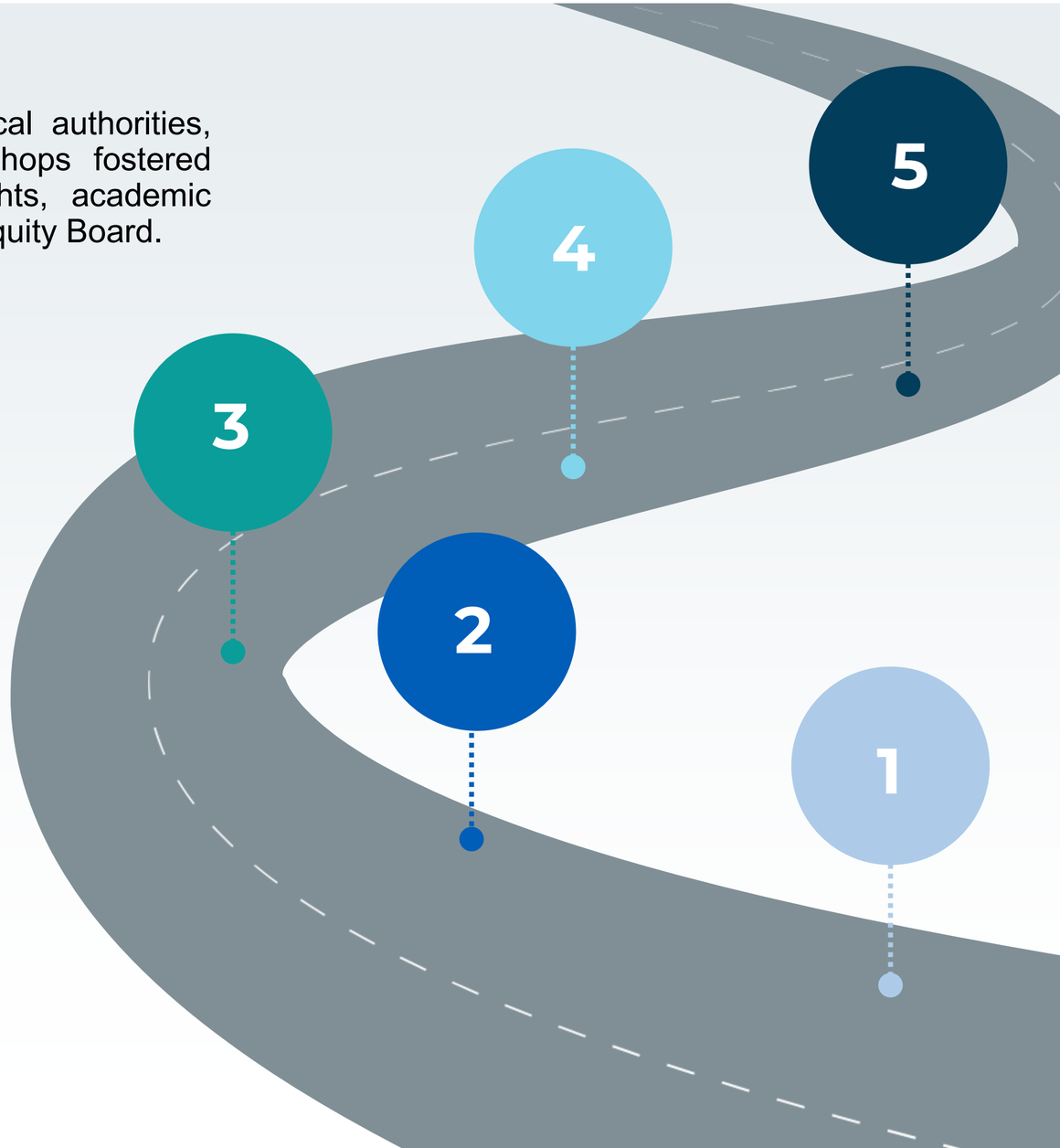
1. **Synthesis of existing data and insights:** undertook a comprehensive review of population health data, insights into the effectiveness of existing interventions, lived experience perspectives, and evidence to demonstrate the value of cost-effective prevention strategies.

2. **Outcomes focus:** co-produced a detailed list of population health outcomes and potential indicators spanning the life course in collaboration with stakeholders, reflecting diverse perspectives and system-wide priorities.

3. **Deep dive into current state:** identified areas for improvement, critical gaps, and enabling actions needed to overcome barriers to drive meaningful impact.

4. **Prevention offer:** developed a three-tiered prevention offer: a core offer of universal interventions; a targeted prevention neighbourhood offer for communities at increasing risk of poorer outcomes; and a prevention offer for secondary and tertiary prevention best delivered across neighbourhoods and boroughs. This was underpinned by a set of prioritised outcomes and recommendations for strategic commissioning and enabling actions.

5. **Testing and socialising:** further testing with partners and residents to inform our approach going forward. The framework has fed into SEL ICB's medium term strategic planning for 26/27 onward, with providers and places to deliver and implement at a local level. The SEL Prevention, Wellbeing and Equity Board will monitor the roll-out and impact of the Prevention Framework.



Prevention Framework Aims

- Embed prevention as ‘business-as-usual’ across the system
- Implement an evidence, data and insight informed SEL prevention offer that will deliver population-level impact at scale and reduce health inequalities
- Optimise resources around prevention and invest in interventions with the greatest opportunity for ROI to support future system sustainability

Pillars of a Prevention Focused System

- Our health behaviours and lifestyles
- The places and communities we live and work in
- An integrated and equitable health and care system
- Wider determinants of health

The Prevention Framework will embed a coordinated approach across SEL to enable earlier support, reduce health inequalities, and ensure system sustainability. Our ambition is to help people remain in the best health possible, for as long as possible, reducing disparities in healthy life expectancy.

Four key pillars underpin the framework’s aims:

- Our health behaviours and lifestyles
- The places and communities we live and work in
- An integrated and equitable health and care system
- Wider determinants of health

The framework aligns national policy with local priorities, fostering collaboration across our partners and recognising that prevention is a long-term effort, requiring evidence-based approaches to deliver measurable benefits for our community.

To deliver our ambitions, the framework sets out **three key outputs** to inform NHS and local authority planning, and influence aligned commissioning opportunities for 2026/27 onwards, including:

1

A **prevention offer** which has been included in the SEL ICS 5-year strategic commissioning and place-based neighbourhood health plans, underpinned by a set of minimum expectations around delivery, outcomes tracking and reporting, and shared learning for year one.

2

A high-level set of **population health outcomes for SEL** to measure impact which have been incorporated into the development of a SEL strategic outcomes and evaluation framework, and be translated into action through appropriate delivery vehicles, e.g. place-based partnerships, care pathway programmes, provider collaboratives.

3

A set of system-level **enabling actions** for high-value prevention activities, required to ensure impactful delivery for population health, equity and sustainability.

These outputs have been created with input from staff working across public health, commissioning, clinical and academic practice and resident insights to ensure they are grounded in evidence and focused on interventions proven to improve population health and tackle inequalities. A Prevention Toolkit has been developed to provide practical resources for decision-making, prioritisation and evaluation of interventions.

Over the next three to five years, we will continue to review and update priorities, identifying further preventative actions to improve population health. Achieving our vision to empower and enable people to live longer, healthier lives requires shared responsibility and commitment across all partners including NHS, local government, businesses and the voluntary and community sector (VCSE).

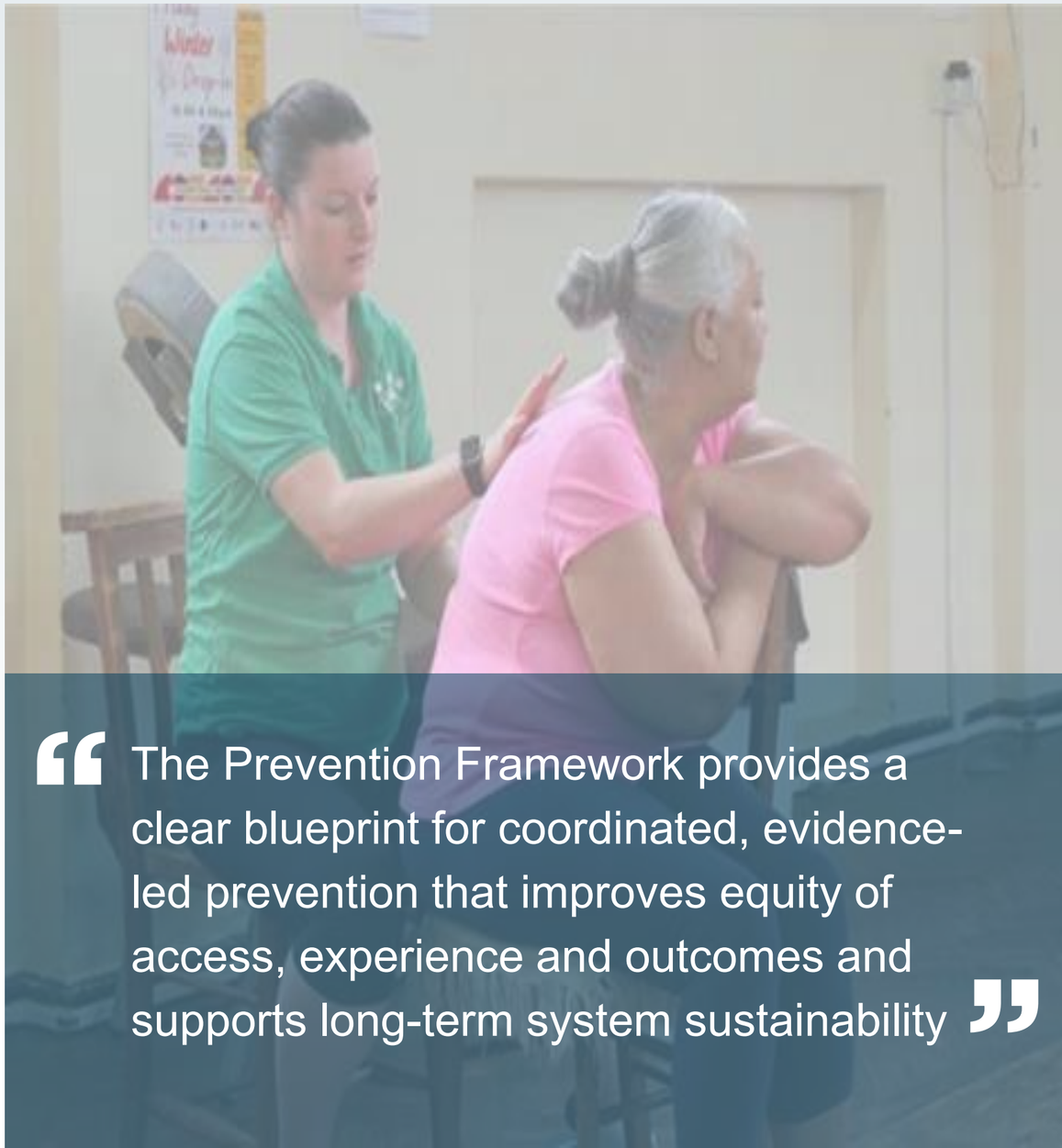
Our thinking

In SEL, a wide range of evidence-based prevention activity is already commissioned across the NHS, local authorities and VCSE partners. However, services are often commissioned and delivered in silos, with inconsistent approaches to monitoring, evaluation and measuring value for money and return-on-investment (ROI) – financial, social and environmental. This makes it difficult to compare interventions, demonstrate financial and social return on investment, and make the case for sustained funding.

Although we collect a lot of data, insights and lived experience, it is rarely triangulated across the system. Information often sits at intervention or organisation level, rather than being joined up to give a population-level view, particularly for communities who face the greatest barriers and inequalities.

Recent SEL population health work has underlined the need for a stronger focus on prevention, early detection and timely intervention for both adults and children and young people, ensuring we take a whole families approach where appropriate.

This approach prioritises reducing health inequalities by targeting those most at risk, including people from minoritised or marginalised communities and those living in areas facing socioeconomic disadvantage. It also drives wider population health impact through universal offers available to everyone regardless of postcode or risk factor.



> “The Prevention Framework provides a clear blueprint for coordinated, evidence-led prevention that improves equity of access, experience and outcomes and supports long-term system sustainability”

What do we mean by prevention in SEL?

Prevention is about helping people stay healthy, happy and independent for as long as possible. It focuses on stopping problems before they arise, not just treating illness when it occurs. It's one of the most cost-effective strategies for improving population health and reducing inequalities.

Adapted from Scotland's Population Health Framework (4)

Wider determinants of health

Interventions aimed at addressing broader social, economic and environmental factors that influence population health

1	2	3
Primary prevention (prevent)	**Secondary prevention** (reduce)	**Tertiary prevention** (delay)
Stopping health problems from happening in the first place	**Reducing** the escalation of health issues	**Supporting** people to remain independent and minimising the impact of health issues

Higher impact ← **Population health impact** → **Lower impact**

Supporting people and our workforce **to live as healthy as possible**, both mentally and physically

E.g., Housing, substance abuse, education, food insecurity, unemployment, travel	E.g., Early detection of risk factors, promoting healthy lifestyles , vaccinations and immunisations	E.g., Health visitor checks, screening services, weight management services, alcohol care teams	E.g., NHS health checks to detect and monitor risk factors, social prescribing and health coaching	E.g., Rehabilitation and reablement, addressing needs of those with long-term conditions or cancer

Driving more proactive and preventative care

The NHS care model has traditionally focused on high-risk residents that use highest resources. These residents typically present with the most complex, severe, or acute conditions or risk factors in their population group. Proactive and preventative targeted support through earlier, tailored neighbourhood-based interventions will help reduce unnecessary escalation and keep people 'as well as they can be' for longer.

Team of teams approach for patients with highest need integrating proactive care via Integrated Neighbourhood Teams (INTs), multi-speciality input, physical and mental urgent and reactive care services and end of life

Proactive integrated Neighbourhood teams supporting residents living with multiple Long-Term Conditions (mLTCs) and frailty – a core team with specialist reach

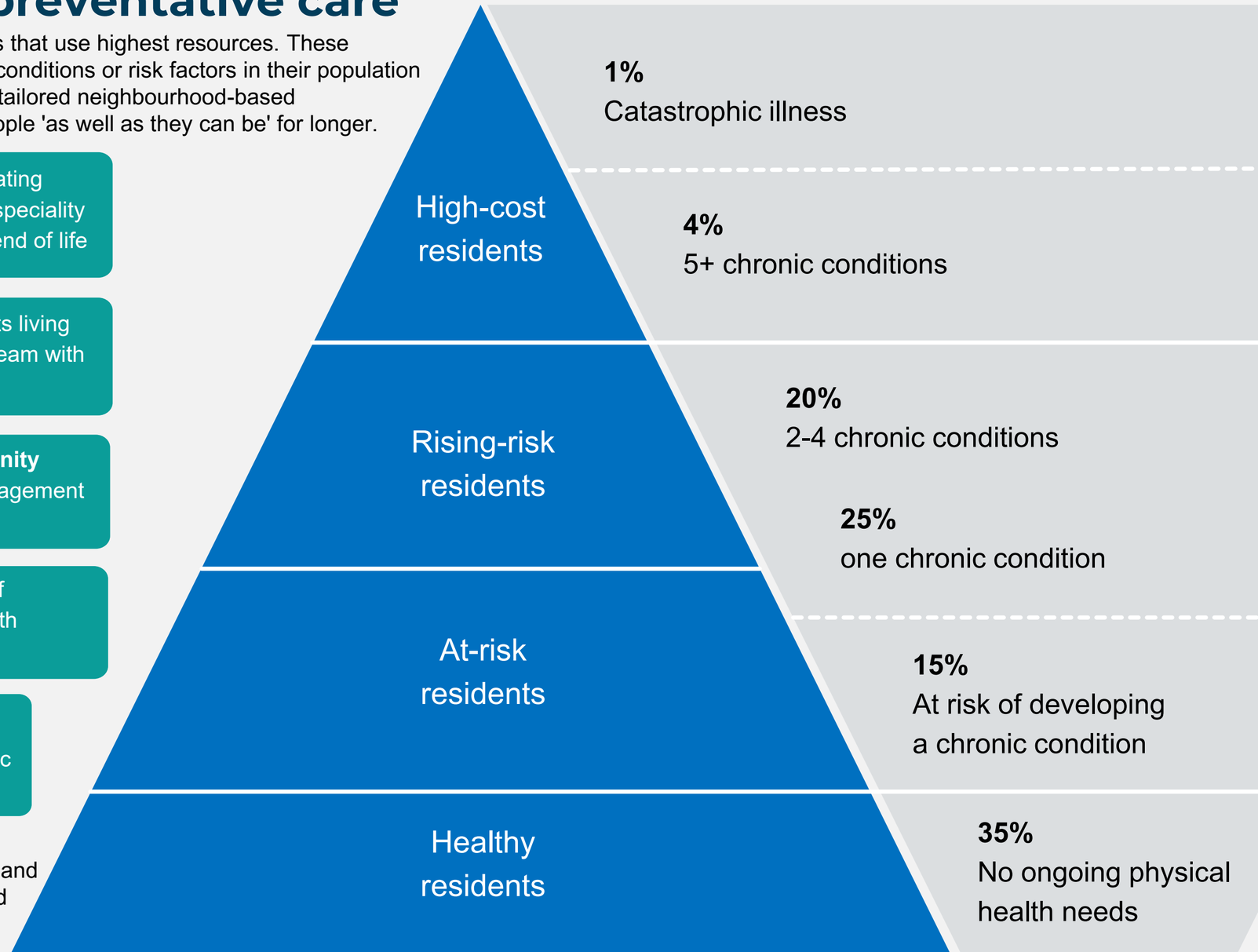
Strengthening consistency and l**evelling up primary and community support for LTC and frailty** identification, care planning and management

Targeted proactive care and support model for those at risk of developing chronic conditions in the future due to entrenched health inequalities

Neighbourhood Asset-Based Health promotion and Prevention (including work and housing). Offers tailored to specific need of resident neighbourhood population

It is acknowledged that this model has been developed through a healthcare lens and will require further work with our local authority and VCSE partners in support of the Prevention Framework delivery and implementation.

Source: Developing approach for neighbourhood care, SEL ICB



The Vital 5

A number of modifiable risk factors – such as smoking, poor diet, physical inactivity, and harmful alcohol use – drive a significant share of preventable illness and early death globally (5). This pattern is also evident in SEL, where these risk factors disproportionately affect minoritised communities and residents living in areas of deprivation. These are known as the **Vital 5**: healthy blood pressure, healthy weight, less drinking, stop smoking and healthy mind.

Our focus on the Vital 5 has enabled more coordinated prevention across SEL, bringing together partners to support awareness, better detect people at risk and provide proactive support tailored to individual needs. To date, via the Vital 5 programme, we have:

- Delivered more than 150,000 Vital 5 Checks to help residents improve their health and wellbeing
- Launched a plan to take action against the growing public health impact of alcohol
- Supported residents to quit smoking and manage their physical and mental health
- Brought together partners and residents to improve weight management services
- Worked with local organisations to provide blood pressure checks in the community

We have reflected learning from our approach to the Vital 5 in our Prevention Framework and sought to enhance our approach to better reflect evidence and insights. This has included:

- Shifting our focus on healthy weight to include physical activity and affordable nutritious food
- Adding key wider social determinant risk factors that should be considered alongside health risk factors
- Ensuring that our approach to the Vital 5 is delivered in the context of making every prevention and wellbeing contact count - for example, vaccinations and immunisations, screening, women's health, pre-diabetes and equipping staff to be prevention focused in their day- to-day interactions with residents.

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 Long Term Plan. 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.

SEL prevention offer

Data and insights on population needs

SEL population health outcomes

Evaluation and learning

Vital 5 Plus wider determinants

- Hypertension
- Unhealthy weight and associated lifestyle factors
- Poor mental health and wellbeing
- Tobacco dependency
- Alcohol harm

- Financial security
- Employment
- Social connectivity
- Housing

Making every prevention contact count (e.g., targeted efforts to increase uptake in vaccinations and screening, small actions our workforce can take to encourage healthier lifestyles and wellbeing)

‘At-scale’ secondary and tertiary prevention

Targeted prevention neighbourhood offer to address inequalities

Universal prevention

Integrated neighbourhood teams

SEL prevention offer

The SEL prevention offer includes three inter-connected tiers:

‘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.

Targeted prevention neighbourhood offer

Designed to enable early detection and intervention for Vital 5 Plus risk factors (see page 13) 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.

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.

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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South East London Integrated Care System

Building blocks of a SEL prevention offer

Principles	**Community led** and clinically informed	Health and wellbeing approach **(holistic)**	**Positive outreach** to engage underserved groups	Consistent and **targeted offer**	Cross-system **collaboration**	Lever for **better maternal and CYP outcomes**

Universal prevention offer

	Healthy promotion and healthy places	Detection and screening
Adults	Vital 5 health promotion campaigns and messaging; accessible information about local and SEL-wide services; consistent approach to alcohol licensing; healthy food and drink provision in health and care settings. For older adults, health promotion spanning strength, balance, movement, brain engagement/social connectivity and nutrition.	Increasing number of brief interventions, with Vital 5 metrics proactively detected through improved screening; community-based ABC testing (arial fibrillation, blood pressure and cholesterol); cancer
CYP	Personal health and social education in schools or community; free school meals; human papillomavirus (HPV) vaccination; school-based interventions.	Adolescent health check; oral health checks and health promotion to nursery and pre-school aged children; mental health in schools.

Targeted prevention neighbourhood offer for populations at rising risk of poorer health outcomes

- Social isolation and loneliness support
- Housing support
- Outreach activities to increase reach
- Income maximisation and workplace health
- Mental health and wellbeing
- Medicines optimisation and pharmacy
- Signposting and referral to tailored prevention services/support
- Falls prevention
- Lifestyle offer (incl. lifestyle medicine and self-management)
- Targeted early detection

'At-scale' secondary and tertiary prevention

For example:

- Smoking cessation services accessible across settings
- Cognitive Behavioural Therapy (e.g. talking therapies)
- Community valve clinics
- Pulmonary rehabilitation for anyone with COPD/and other breathing issues and difficulties
- Single point of access and community-wrap around model for weight management services

Integrated neighbourhood teams

Enabling infrastructure

- Funding
- Digital
- Workforce
- Population health management

Prevention-focused population health outcomes

By 2035, SEL ICS aims to increase the likelihood that people will remain in the best health they can be for as long as possible, and in doing so, reduce disparities in healthy life expectancy.

The SEL Prevention Framework is focusing on addressing key areas of health challenge for SEL upstream e.g. complex CYP, and rising risk of poor cardio-metabolic health, and frailty

The SEL prevention offer is aligned to a prioritised set of system-level outcome statements, which include markers for progress in the short and medium term. This prioritises efforts to improve population health and reduce inequalities, particularly for underserved groups, and establishes a foundation for future prevention-focused action across working age adults, children and young people, and maternity and neonates.

There are also specific outcomes supporting the workforce, given the Prevention Framework is positioned as an opportunity to increase preventative impact for our residents and our work and care force including informal carers.

These outcomes statements will feed into wider SEL ICS efforts to establish Population Health outcomes, alongside other outcome frameworks (e.g., SEL Ageing Well Framework and SEL Neighbourhood Working Framework). This will include the development of indicator metrics and benchmarks, and the ability to split key demographic factors, such as protected characteristics and levels of deprivation, to identify whether specific groups require additional focus or resource allocation.

SEL ICS long-term ambitions

- Reducing the inequality gap in healthy life expectancy.
- Ensuring a good start in life and reducing inequalities in child health outcomes and development.
- Building trust and confidence in preventative healthcare services in our communities.
- Reduction in preventable deaths due to infectious disease and chronic disease.
- Reducing the gap between mental and physical health outcomes.

KING'S HEALTH PARTNERS

South East London Integrated Care System

Prevention neighbourhood offer – taking a life course approach

Prioritised population health outcomes

Inputs

Strategic use of commissioning investment | Workforce | Partnerships enabling collaboration | Evidence base and insight informed policies | Resident, carer and family voice

Community spaces | Population health management capability | Digital and artificial intelligence | National prevention programmes | Care pathways

Maternal and neonates at rising risk of poorer health outcomes

Activities

- Implementation of national programmes and best practice care pathways for maternity, neonatal and mental health
- Deliver training for maternity and neonatal staff
- Incorporate service user in design and evaluation of maternity and neonatal services
- Provision of accessible information
- Promote use of community spaces for parenting support
- Implementation of targeted care to reduce unwarranted variation and avoidable incidents
- Implementation of preventative / preconception measures
- Embed the delivery of relational /personalised care across SEL maternity units

Lead markers for progress

- Compliance data for maternity and neonatal evidence-based improvement programmes
- Number of staff attending training in advocacy, cultural sensitivity, trauma informed care and communication.
- Number of avoidable maternal and neonatal deaths, and morbidities
- Number of women receiving life course health management when they have experienced complexities due to pregnancy and/or childbirth

3 – 5-year outcomes

1. **Increased** staff knowledge and skills in advocacy, cultural sensitivity, trauma informed care and communication
2. **Decreased** avoidable perinatal mortality and morbidity
3. **Improved** interface between maternity and neonatal providers and other specialties (e.g., mental health)
4. **Increased** number of higher-risk women receiving life course screening for diabetes, cardiovascular disease and mental health.
5. **Embedded** service user voice in service transformation, delivery and care
6. **Embedded** pre-pregnancy health across SEL to support people planning for healthy pregnancy birth and beyond

Children and young people at rising risk of poorer health outcomes

Activities

- Diagnosis of asthma in primary and community care
- Delivery of routine childhood vaccinations, including HPV catch-up programmes for those who missed vaccination in Year 8
- CYP participation in regular physical activity
- Embed mental health support within physical health pathways
- Enable enhanced understanding of mental health and wellbeing among CYP, parents/carers, and healthcare professionals
- Delivery of community programmes that support early detection of mental health needs
- Delivery of mental health education and support to parents and/or peer support

Lead markers for progress

- Number diagnosed with asthma in primary and community care; number of exacerbations and hospital admissions
- Uptake of routine and HPV vaccinations
- Number participating in regular physical activity through educational/community settings
- Number screened for overweight/obesity
- Number of preventable hospital admissions
- Number of families engaged with mental health and wellbeing support and interventions
- Number of community programmes delivering mental health interventions and support to CYP
- Knowledge across the health system of mental health and wellbeing

3 – 5-year outcomes

1. **Reduce** asthma mortality and emergency admissions for asthma
2. **Reduce** gap in mental and physical health outcomes between areas of high and low deprivation
3. **Decrease** prevalence of childhood obesity
4. **Increase** uptake of routine childhood vaccinations, including HPV catch-up programmes for those who missed vaccination in Year 8
5. **Improve** CYP mental health and wellbeing.
6. **Reduce** preventable hospital admissions by improving joint management of physical and mental health conditions

Working age adults at rising risk of poorer health outcomes (e.g., Cardiovascular-renal-metabolic health or frailty)

Activities

- Early detection, screening and management of long-term conditions and risk factors (e.g., Vital 5)
- Medicine optimisation, self-management support and promotion of healthier behaviours (supported by digital)
- Train healthcare providers on prevention and risk management
- Early detection of mental health conditions in primary care
- Delivery of accessible community-based interventions for adults with long term conditions, risk factors and/or common mental health issues (that include peer support)
- Deep-rooted listening and community organising with underserved communities

Lead markers for progress

- Number screened for Vital 5 risk factors and/or long-term conditions
- Number referred to, engaging with and completing Vital 5 interventions /prevention interventions such as weight management programmes, smoking cessation and talking therapies
- Use of NHS-approved digital self-management and prevention tools
- Cancer screening coverage
- Self-reported physical activity levels in adults
- Number of community-based interventions delivering lifestyle medicine, structured education, health coaching
- Number of healthcare professionals trained in prevention and risk factors.
- Knowledge and understanding across the health system of mental health and wellbeing, with links to workplaces and communities

3 – 5-year outcomes

1. **Reduce** inequality in the detection, screening and management of risk factors and long-term conditions, through early targeted interventions for priority populations; and people living in deprived neighbourhoods

2. Reduce prevalence of Vital 5 risk factors

3. Reduce demand for unplanned/planned care services through earlier identification, diagnosis and improved management of long-term conditions, including cancer and women's health.

4. Improve trust and confidence in health and care services; resulting in higher uptake and more equitable access

5. Improve earlier stage cancer diagnosis and equitable uptake of national screening programmes for: breast, bowel, cervical, and lung cancer

6. Increase individual activation and self-management of physical and mental health supported by holistic detection and collaboration with housing, employment, and social services

Long-term ambitions

- Build trust in preventative services
- Reduce gap between mental and physical health outcomes
- Reduce preventable deaths due to infectious and chronic diseases
- Ensure a good start in life and reduce child health inequalities
- Reduce healthy life expectancy inequalities

Our plan

Engagement with partners across SEL ICS has highlighted ‘foundational’ building blocks to enable and support the realisation of our ambitions. These require a set of system-level **enabling actions** to overcome potential barriers to success:

Enabling a more comprehensive understanding of population needs across SEL, the evidence-base for prevention, and gaps that require collaborative action across SEL ICS. This will involve collaborative working with partners across the SEL ICB business intelligence team, SEL public health analytics network and KCL Population Health Institute.

Incorporating the high level prioritised outcomes for prevention into a standardised approach for a system-level outcomes framework (including lead markers for short and medium term on/off track assessments) and frameworks for return on investment and social return on investment (ROI/SROI) that can be applied more broadly in support of strategic commissioning for prevention and early intervention across health and care.

Adjusting our funding and planning approaches to enable SEL ICB (at system and place) and local authority partners to ensure resources are appropriately directed towards prevention and capacity building to enable health creation. This should be alongside other key enablers such as population health management, digital innovation, and embedding prevention as a key priority for SEL ICS workforce development, with inclusion of VCSE partners and carers as part of overall ‘making every prevention contact count’ endeavours.

Developing a toolkit for high-impact prevention that can practically support teams on the ground who are involved in the commissioning, delivery and improvement of preventative interventions, pathways and models of care.

Supporting information

Abbreviations

AF	Atrial Fibrillation
BMI	Body Mass Index
BP	Blood Pressure
CAMHS	Children and Adolescent Mental Health Services
COPD	Chronic Obstructive Pulmonary Disease
CYP	Children and Young People
HCP	Health Care Professionals
HPV	Human papillomavirus
ICB	Integrated Care Board
ICS	Integrated Care System
INT	Integrated Neighbourhood Team
JSNA	Joint Strategic Needs Assessment
KCL	King’s College London
LD	Learning Disability
LTC	Long Term Condition
MNVP	Maternity and Neonatal Voices Partnerships
ROI	Return on Investment
SROI	Social Return on Investment
SEL	South East London
SMI	Serious Mental Illness
VCSE	Voluntary, Community, and Social Enterprise

Acknowledgements

South East London Integrated Care Board (SEL ICB) and King's Health Partners are grateful to the following for their input to the Prevention Framework.

- Members of the SEL Prevention, Wellbeing and Equity Board
- Members of the multi-disciplinary coordinating group
- Care pathway leads spanning SEL ICB, local authorities and VCSEs
- Cordis Bright

We extend our gratitude to all participants in the 2025 Prevention Framework workshop series for their valuable contributions to testing and refining our approach, with particular appreciation to our SEL VCSE and resident organisations for including SEL residents' voices.

Insights gained from people and communities in SEL have significantly informed the Prevention Framework. We recognise that building trust and developing relationships takes time and commitment. We know from previous work within the system that residents are asked repeatedly to engage in co-design but don't always see the result therefore we undertook an exercise to synthesise insights from across the system.

SEL ICS Engagement Teams and VCSE Alliance have been involved in leading and shaping this work. As Neighbourhood working continues to evolve, and we develop our approach to prevention, we will continue to engage with communities to understand their needs with respect to developing and implementing prevention interventions.

Building trust and strong relationships with communities takes time and is essential for success. The Trust and Health Creation initiative will play a key role by co-developing a practical blueprint to achieve this effectively.

References

1.Foundational elements - SEL narrative. October 2025
2.Unlocking prevention in integrated care systems NHS Confederation in partnership with Carnall Farrar (2024)
3.Health Index for South East London, Ethica Health Partners. October (2025)
4.Scotland's Population Health Framework, COSLA and Scottish Government. (2025)
5.Global Burden of Disease study, IHME (2023)

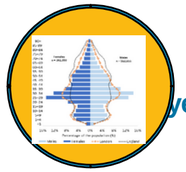
Appendix A

Borough health profiles

Health in Lambeth Summary, 2024

Demography

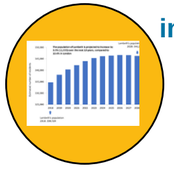
Structure



49% 20-44 years age group

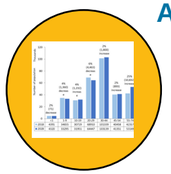
Lambeth has a **young population** profile

Population trends



2.5% increase

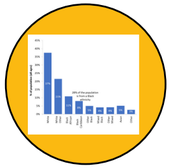
8,300 increase in population expected between 2023-28



Ageing

12% increase expected in 75+ group

Population diversity



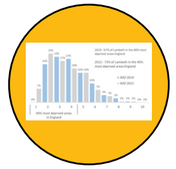
Ethnically diverse population Black, Asian and Multi-Ethnic community **62%**

24% from Black Ethnicity; **17%** White Other ethnic group

Social and economic determinants of health

One in five of Lambeth's residents live in an area in the 20% most deprived in England

18% of children in low income families & **30%** older people are income deprived

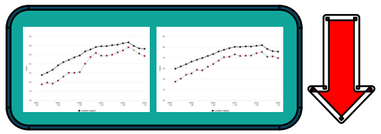


These disadvantaged communities experience the highest levels of underlying **health issues** and **preventable mortality**

Health Profile

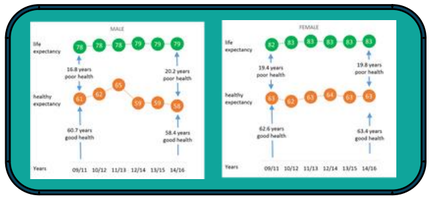
Life expectancy

Men 78
Women 83



Life expectancy at birth is **decreasing.** The gap between Lambeth and London is **widening**

Healthy life expectancy



People are living between **17 and 24 years in poor health** from a range of long term & multiple conditions

Risk factors

Avoidable risk factors are **smoking, obesity, poor diet, alcohol, drug misuse and high blood pressure** across the life course

Other determinants of health

Natural & Built Environment

- **AHAH index[4]**
- **Noise**
- **Air pollution**
- **Road traffic accidents**

67%

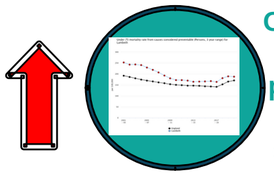
Education

1,805 children achieving **good level of development** at end of Reception

Violent crime is an important issue. **Youth crime & first time offender** rates are **decreasing** but still high compared to England

Health Profile

Deaths



On average 350 preventable deaths each year

Since 2017-19, the preventable and overall mortality rate has **increased**

Avoidable deaths

Account for **32%[1]** of all deaths. Common causes are from **Cancer, Cardiovascular, Respiratory, Injury related disorders & drug misuse deaths.** Significant differences exist between the least & most deprived areas of Lambeth

Health protection priorities

Tuberculosis incidence

Childhood vaccinations COVER programme[2]

Adult vaccinations flu, PPV[3], shingles

Main diseases & long term conditions of residents

Musculo-skeletal: back & neck pain

Serious Mental Illness

Sexual health

Migraine headache

Skin disorders

Health in Royal Greenwich Summary, 2025

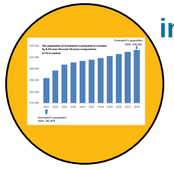
Demography

Structure

49% 20-49 years age group

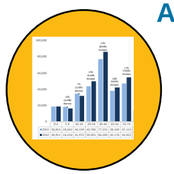
Greenwich has a **young population** profile

Population trends



2.4% increase

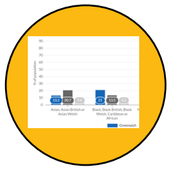
7,300 increase in population expected between 2025-30



Ageing

18% increase expected in 75+ group

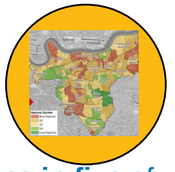
Population diversity



Ethnically diverse population Black, Asian and Multi-Ethnic community **40%**

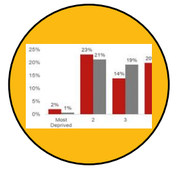
21% from Black Ethnicity; **12%** White Other ethnic group

Social and economic determinants of health



One in five of Greenwich's residents live in an area in the 20% most deprived in England

22% of children in low income families & **21%** older people are income deprived

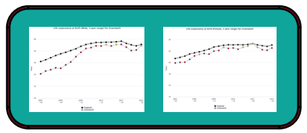


These disadvantaged communities experience the highest levels of underlying **health issues** and **preventable mortality**

Health Profile

Life expectancy

Men 78
Women 83

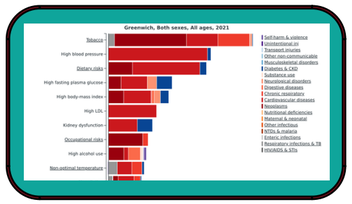


Life expectancy at birth is stable**.** The gap between Greenwich and London has **narrowed**

Healthy life expectancy

People are living between **19 and 23 years in poor health** from a range of long term & multiple conditions

Risk factors



Avoidable risk factors are **smoking, High Blood pressure, poor diet, obesity, alcohol, and high cholesterol** across the life course

Other determinants of health

Income & vulnerability
1,327 Households with dependent children owed a duty under homelessness reduction act (highest in London (35/1,000)

70%

Education

2,232 children achieving **good level of development** at end of Reception

Domestic Abuse related incidents and crimes remain an important issue.
Rates remaining steady at 22/1,000 (lower than London and England)

Health Profile

Deaths

On average 296 preventable deaths each year

Since 2017-19, the preventable and overall mortality rate has **increased**

Avoidable deaths

Account for **41%**[1] of all deaths. Common causes are **Cancer, Cardiovascular, Respiratory, and Mental disorders.**

Health protection priorities

Childhood vaccinations COVER programme[2]

HIV Diagnosis

Tuberculosis incidence

Main diseases & long term conditions of residents

Musculo-skeletal

Serious Mental Illness

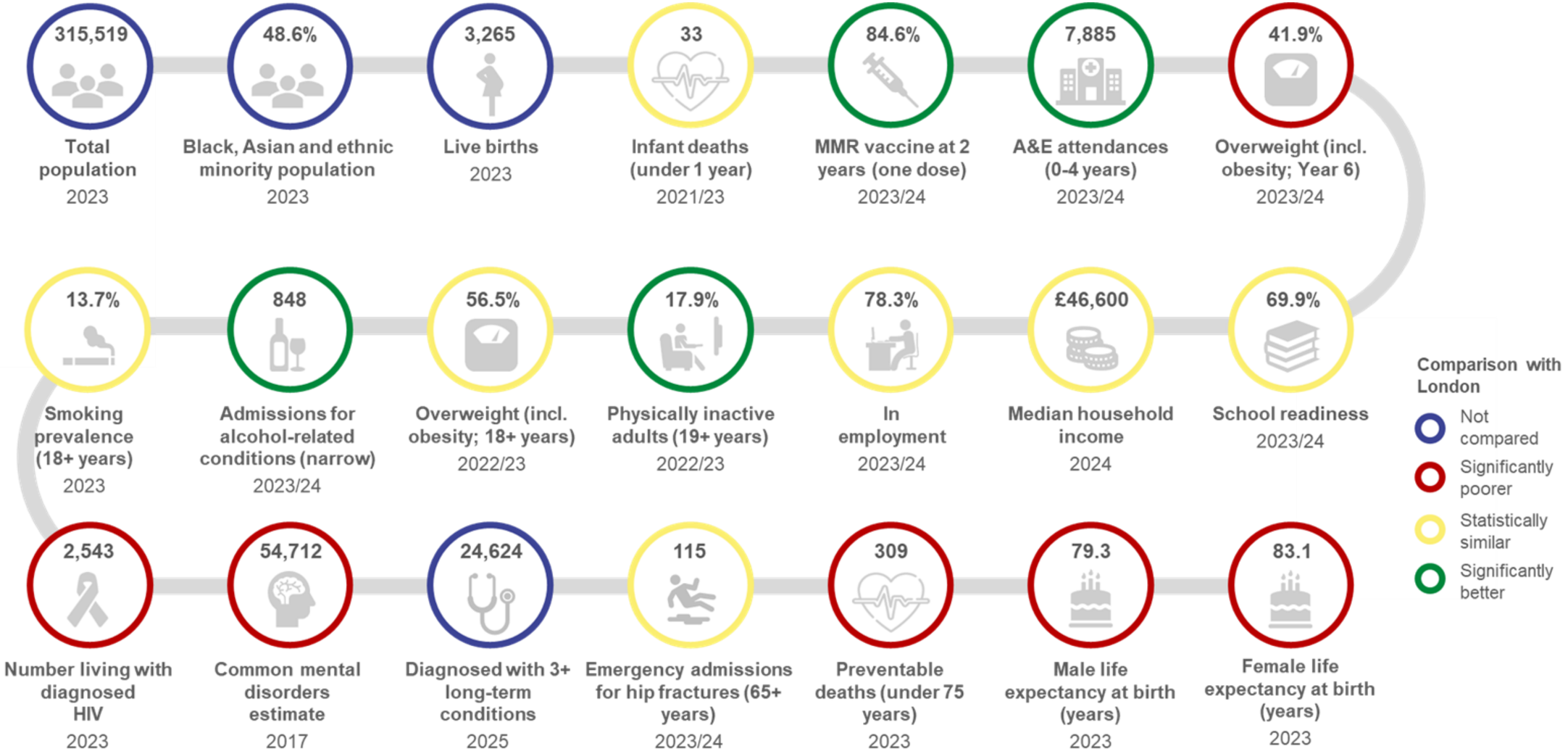
Injuries

Neurological conditions

Diabetes

Significant differences exist between the least & most deprived areas of Greenwich

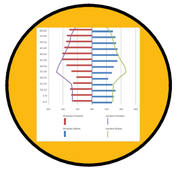
Health in Southwark Summary



Health in Bromley Summary 2025

Demography

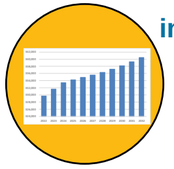
Structure



53% aged over 40

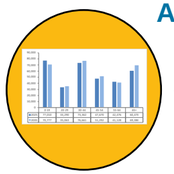
Bromley has an **older population** than the London-wide average

Population trends



2.9% increase

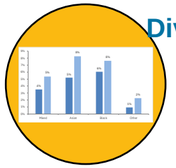
10,000 increase in population expected between 2025-35



Ageing

15% increase expected in 65+ group

Population diversity



Diversifying

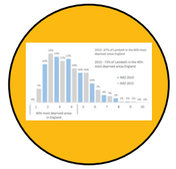
Minority ethnic population grew **8 percentage points** in 10 years

24% from a Minority Ethnic group

Social and economic determinants of health

One in 14 of Bromley's residents live in an area in the 20% most deprived in England

9.8% of children in low income families & **10.2%** older people are income deprived

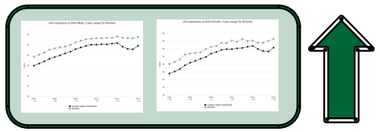


These disadvantaged communities experience the highest levels of underlying **health issues** and **preventable mortality**

Health Profile

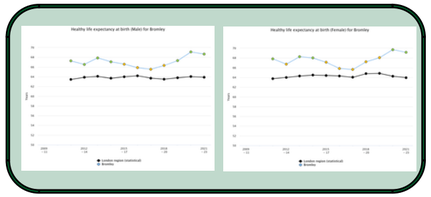
Life expectancy

Men 81.5
Women 85.3



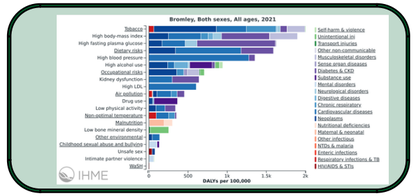
Life expectancy at birth is **recovering** after Covid

Healthy life expectancy



People are living between **12.8 and 16.1 years in poor health** from a range of long term & multiple conditions

Risk factors



Avoidable risk factors are **smoking, obesity, poor diet, alcohol, drug misuse and high blood pressure** across the life course

Other determinants of health

Lifestyle

- **32%** year 6 overweight
- **Low** utilisation of outdoor space

73%

Education

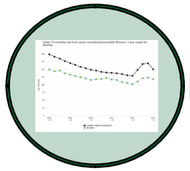
2,795 children achieving **good level of development** at end of Reception

Crime

Low rates of violent crime and first time entrants to youth justice system

Health Profile

Deaths



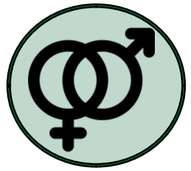
In 2023, 311 preventable deaths occurred

These are deaths which may have been avoided with effective primary prevention

Preventable deaths

Account for **45%** of all deaths under 75.
People in the most deprived fifth of Bromley have higher mortality rates from **circulatory and respiratory conditions, and cancer**

Health protection priorities



Increase STI and HIV testing rate

Childhood vaccinations COVER programme[1]

Adult vaccinations flu, PPV[2], shingles

Burden of disease

Musculoskeletal disorders

Mental disorders

Neurological disorders

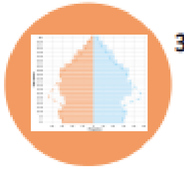
Other non-communicable diseases

Diabetes and CKD

Health in Bexley Summary, 2025

Demography

Structure



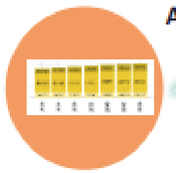
37% aged <16 or 65+

Bexley has **more children** and **older people** than London

Population trends

5.8% increase

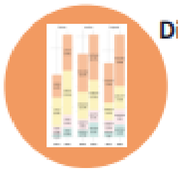
14,700 increase in population expected between 2025-35



Ageing

21.9% increase expected in 65+ group

Population diversity



Diversifying

Minority ethnic population grew **9.9 percentage points** in 10 years

1 in 10 are from a Black African background & **1 in 10** are from an Asian background

Social and economic determinants of health

One in 18 of Bexley's residents live in an area in the 20% most deprived in England

13.6% of children in low-income families & **10.9%** older people are income deprived

These disadvantaged communities experience the highest levels of underlying **health issues** and **preventable mortality**

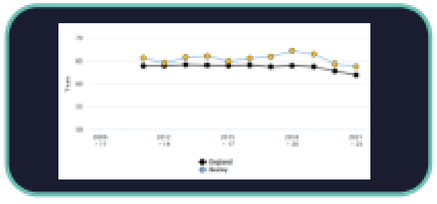
Health Profile

Life expectancy

Men 80.1
Women 83.3

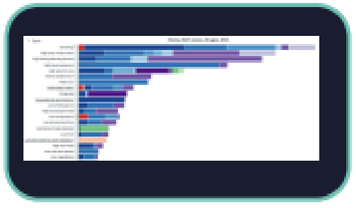
Historical improvements in life expectancy have **plateaued** and fallen behind London

Healthy life expectancy



People are living between **15.9 and 19.5 years in poor health** from a range of long term & multiple conditions

Risk factors



Avoidable risk factors are **smoking, obesity, poor diet, alcohol, drug misuse and high blood pressure** across the life course

Other determinants of health

Lifestyle

- Low rates of physical activity in children and adults
- Low utilisation of outdoor spaces

71.4%

Education

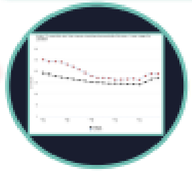
2,157 children achieving **good level of development** at end of Reception

Crime

Low rates of admissions for violent crime

Health Profile

Deaths



On average 276 preventable deaths occur each year

These are deaths which may have been avoided with adequate primary prevention

Excess deaths

People in the most deprived fifth of Bexley have higher mortality rates from circulatory and respiratory conditions, and cancer.

Health protection priorities

Chlamydia detection

Childhood vaccinations COVER programme[1]

Adult vaccinations flu, PPV[2]**, shingles**

High burden conditions

Musculo-skeletal: back & neck pain

Mental Illness

Neurological

Sense organ diseases

Diabetes and CKD

Health in Lewisham Summary, 2025

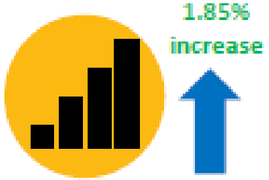
Demography

Structure

43% 20-44 years age group

Lewisham has a young population profile

Population trends



1.85% increase

5,400 increase in population expected between 2023-28

Ageing

5% increase expected in 75+ group

Population diversity

Ethnically diverse population Black, Asian and Multi-Ethnic community 63%

27% from Black Ethnicity; 12% White Other ethnic group. Spanish most spoken language after English

Social and economic determinants of health

Almost 1 in 4 of Lewisham's residents live in an area in the 20% most deprived in England

19% of children in low income families & 24% older people are income deprived

These marginalised communities experience the highest levels of underlying health issues and preventable mortality

Health Profile

Life expectancy

Men 78
Women 83

Life expectancy at birth has stalled. The gap between Lewisham and London is widening

Healthy life expectancy

People are living between 21 and 26 years in poor health from a range of long term & multiple conditions

Risk factors

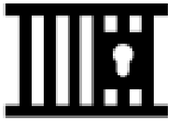
Avoidable risk factors are smoking, obesity, poor diet, alcohol, drug misuse and high blood pressure across the life course

Other determinants of health

Housing
20.52 households per 1,000 live in temporary accommodation

73%

Education
2,279 children achieving good level of development at end of Reception



Violent crime is an important issue. Youth crime & first time offender rates are decreasing but still higher than England

Health Profile

Deaths

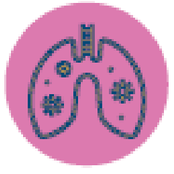
On average 337 preventable deaths each year

From 2018-20 onwards, the preventable and overall mortality rate has increased

Avoidable deaths

Account for 31% of all deaths. Common causes are from Cancer, Cardiovascular, Respiratory, Injury related disorders & drug misuse deaths. Significant differences exist between the least & most deprived areas of Lewisham

Health protection priorities



Infectious diseases - Measles and Tuberculosis

Immunisations and vaccines - all ages and during pregnancy

Screening including - NHS Health Checks & Cancer

Other Relevant Information

Unpaid care: 7.1% of Lewisham residents provide unpaid care each week

6% of the population stated their sexual orientation was other than heterosexual or straight

1% of the population stated their gender identity was different to that assigned at birth