

**“Good support isn’t just about
‘services’ – it’s about having a**



Informing the Design of a Prevention and Early Intervention Adult Social Care Framework for Northern Ireland Evidence Review Report

Dr Obert Tawodzera, Dr Mary Webster and Barbara Campbell, May 2026

Contents

Executive Summary	4
1. Introduction	6
1.1 Background	6
1.2 Northern Ireland Context	8
1.3 Aim of the Review	9
1.4 Policy Context in Northern Ireland	10
1.5 Commission and Scope of the Review	11
1.6 Structure of the Report	11
2. Methodology	12
2.1 Review Approach: Rapid Evidence Synthesis	12
2.2 Search Strategy and Information Retrieval	12
2.3 Selection of Jurisdictions	13
2.4 Inclusion and Exclusion Criteria	14
2.5 Data Extraction and Thematic Synthesis	14
2.6 Quality Assurance and Limitations	15
3. Defining Prevention and Early Intervention	15
3.1 Introduction	15
3.2 The Challenge of Defining Prevention in Social Care	16
3.3 The Prevention Continuum: Upstream to Downstream	17
3.4 Distinguishing Prevention from Early Intervention	17
3.5 Operationalising Prevention: Universal, Targeted, and Reablement Approaches	18
3.6 Economic and Wellbeing Framings	19
3.7 Asset-Based and Capability Approaches	19
3.8 Addressing Social Determinants and Inequalities	20
3.9 Proposed Working Definitions for Northern Ireland	20
4. International Evidence: What Works and Why	21
4.1 Introduction	21
4.2 England: Mandated Prevention Through Funding and Regulation	22
4.3 Scotland: National Mission and Technology Investment	23
4.4 Wales: Statutory Partnerships and Regional Delivery	24
4.5 Scandinavia: Legislated Reablement and Preventive Outreach	25

4.6 Australia: Prevention Built into National Scheme Design	26
4.7 Canada: Integrated Care, Community Innovation, and Workforce Investment	27
4.8 Emerging Themes	29
4.9 Implications for Northern Ireland	31
5. How Success is Measured	32
5.1 Introduction	32
5.2 Denmark: National Prevention Indicators	32
5.3 Sweden: Senior Alert and Real-Time Monitoring	33
5.4 Canada and Australia: Equity, Workforce, and Algorithmic Risk	35
5.5 Towards a Measurement Framework for Northern Ireland	36
5.6 Implications for Northern Ireland	37
6. Enablers and Barriers to Implementation	38
6.1 Introduction	38
6.2 The Policy–Practice Gap	38
6.3 National Enablers: Creating the Conditions for Prevention	39
6.4 Local Enablers: Translating Policy into Practice	40
6.5 Persistent System Barriers	41
6.6 Mechanisms for Successful Implementation	42
6.7 Implications for Northern Ireland	43
7. Recommendations for Northern Ireland	44
7.1 Overarching Strategic Recommendation	44
7.2 Specific Recommendations	46
7.3 Phased Implementation Approach	51
8. Conclusion	53
8.1 Summary of Key Findings	53
8.2 Implications for Northern Ireland	55
8.3 Final Reflection	56
References	56

Executive Summary

Adult social care systems across the developed world face sustained pressure from demographic ageing, financial constraints, and workforce shortages. In response, there has been a significant international policy shift toward prevention and early intervention. Northern Ireland's Department of Health has committed to developing a comprehensive preventative adult care and support framework as part of its 10-year strategic plan for adult social care reform (Department of Health, 2026a, 2026b).

This evidence review was commissioned to inform the development of that framework. Its purpose is to gather, assess, and synthesise evidence, research, and best practice from Northern Ireland, the wider United Kingdom (UK), and international literature. The review examines evidence from England, Scotland, Wales, Scandinavia (Denmark, Norway, Sweden), Australia, and Canada.

A consistent finding across the literature is the lack of a clear, shared definition of prevention in adult social care. This ambiguity has been described as a fundamental barrier to policy development and effective implementation (Godfrey, 2001; Verity et al., 2022). This review adopts the three-tier prevention continuum: primary prevention (universal, community-based support to keep people healthy and independent); secondary prevention (targeted early intervention for those at risk); and tertiary prevention (reablement and rehabilitation to restore independence after decline).

The evidence base is strongest for reablement and falls prevention. Reablement consistently improves functional independence, reduces reliance on ongoing care, and is cost-effective (Welsh Government, 2021; Rostgaard, 2018). The Härnösand model in Sweden achieved a 93 per cent reduction in care needs among participants (Interreg Europe, 2025). Falls prevention programmes demonstrate significant reductions in falls and related hospital admissions among high-risk populations.

Community-based prevention, including social prescribing, consistently improves wellbeing and social connectedness, but evidence for reductions in health and social care utilisation is less robust (Terje et al., 2022; Keemink et al., 2023). This may reflect identification of unmet needs rather than failure of interventions.

International evidence demonstrates that prevention is most effective when embedded in legislation and funding mechanisms. England uses mandated funding through the Better Care Fund. Scotland has invested heavily in technology and community alternatives. Wales has established statutory Regional Partnership Boards. Scandinavia has legislated reablement as the default response. Australia has embedded prevention in national scheme redesign. Canada offers lessons in integrated care models and workforce investment.

Significant evidence gaps remain, including limited evidence on social care outcomes, fragmented cost-effectiveness evidence, uneven evidence across populations and interventions, and underdeveloped evidence on inequalities. These gaps must be addressed through a coordinated research programme including a prevention outcomes measurement framework, pilot evaluations, and investment in implementation science.

Based on the evidence reviewed, seven recommendations are proposed for Northern Ireland:

- adopt a statutory prevention framework;
- establish clear operational definitions;
- establish reablement as the default tertiary prevention pathway;
- implement systematic risk identification;
- invest in workforce capability;
- develop integrated data infrastructure; and
- strengthen community and voluntary sector partnerships.

The evidence is clear. Prevention in adult social care is achievable, effective, and cost-effective when implemented systematically. Northern Ireland's integrated health and social care system provides a strong foundation. The Department of Health has committed to a preventative framework. The window of opportunity is open. The blueprint exists. The task now is to act.

1. Introduction

1.1 Background

Adult social care systems across high-income countries are experiencing sustained and increasing pressure. This pressure is being driven by several interrelated factors: demographic ageing, rising prevalence of long-term and complex conditions, increasing expectations regarding quality of life and independence in later life, and ongoing workforce challenges relating to recruitment, retention, and capacity. Collectively, these trends are reshaping the demand placed on health and social care systems and intensifying the need for new approaches to service delivery (Wong et al., 2025).

Population ageing is occurring at a scale and pace that will have significant implications for future care demand. In Northern Ireland, although the overall population is projected to decline by 2049, the number of older adults is expected to continue rising. The population aged 65 years and over is projected to increase by 44.7 per cent, while the number of people aged 85 years and over is expected to more than double, increasing by 126.1 per cent (NISRA, 2026). This demographic change is likely to be accompanied by an increase the prevalence of long-term health conditions and disabilities. An estimated 460,000 people in Northern Ireland currently live with a long-term, limiting health condition or disability, and this number is expected to rise as the population ages (McMullen et al., 2026).

Mental health conditions represent a significant proportion of disability and are the third highest contributor to disease and disability in Northern Ireland (O'Neill, 2026). The need for mental health support is substantial, with an estimated 18 per cent of adults experiencing poor mental health and 38 per cent reporting concerns about their own mental wellbeing during 2024-2025 (Department of Health, 2025). Mental health crises also place considerable financial pressure on services, costing approximately £45 million annually (McDaid et al., 2026). However, an estimated two-thirds of people experiencing a mental health crisis could be supported through community and voluntary services, representing potential annual savings of more than £9 million (McDaid et al., 2026).

Despite this significant need, many people in Northern Ireland experience substantial barriers to accessing health and social care, with workforce shortages and lengthy waiting times reflecting a system under considerable pressure and struggling to meet population needs (Department of Health, 2026c). The mental health landscape in Northern Ireland has been shaped by the complex interplay of political instability, financial pressures and wider social change, with demand for support services expected to continue increasing in the absence of effective and sustainable reform (O'Neill, 2026).

These demographic pressures are compounded by the reality of constrained public finances and increasing demand across health and care systems. The result has been growing concern internationally that many systems have become predominantly reactive in nature, responding to crisis and escalating need rather than intervening earlier to maintain independence and wellbeing (Keemink et al, 2023). Historically, adult social care systems have largely been designed around responding to significant deterioration in health or functioning (Hoddinott, 2025). Support is frequently triggered only once individuals reach high eligibility thresholds or experience a crisis that necessitates intervention (Bottery, 2024; Tew et al., 2023). While this model provides an essential safety net, it has also been associated with poorer individual outcomes, reduced opportunities for maintaining independence, increased pressure on family carers, and greater reliance on acute hospital and residential care services (Tew et al., 2023).

Over the past two decades, this has prompted a significant international policy shift towards prevention and early intervention. Increasingly, governments and care systems are seeking to move from reactive models of care towards approaches that proactively support people to maintain independence, health, wellbeing, and social participation for as long as possible. Prevention in this context is not solely concerned with reducing demand on services; rather, it reflects a broader ambition to support people to live well, remain connected to their communities, and exercise greater choice and control over their lives (Lette et al, 2015).

Importantly, however, the need for care and support is not experienced equally across the population. There is strong evidence that social determinants of health – including

poverty, housing, education, employment, and social exclusion – have a significant impact on health outcomes, disability, and the likelihood of requiring social care support later in life. McNally (2020) highlights that people living in the most deprived communities experience illness and disability significantly earlier than those living in more affluent areas. The study found that individuals in deprived areas are affected by illness approximately 19 years earlier than those in less deprived areas. Similarly, 43 per cent of people aged over 65 living in deprived areas require support with activities of daily living, compared to 22 per cent in less deprived areas (McNally, 2020).

These inequalities are particularly important within the context of prevention and early intervention. Evidence consistently demonstrates that preventative approaches are most effective when they are designed to address wider social determinants of health and when access to support is equitable across different communities and population groups (Thiery et al, 2023). Consequently, prevention cannot be understood solely as a service-level intervention; it must also be considered within the wider context of social policy, inequality, and community wellbeing.

1.2 Northern Ireland Context

Northern Ireland operates a distinct integrated health and social care (HSC) system in which health and social care services are commissioned and delivered within a single organisational structure. Unlike the arrangements that exist across much of Great Britain, this integrated model provides a potentially strong foundation for coordinated, person-centred approaches to prevention and early intervention (Chapman, 2020).

The structural integration of services offers important opportunities for earlier identification of need, improved coordination between professionals, and more seamless pathways between primary care, community services, hospital services, and adult social care (Dayan et al., 2019). In principle, the HSC model is well positioned to support approaches that focus on maintaining independence, avoiding unnecessary hospital admissions, and enabling people to remain living well at home for longer.

However, international evidence demonstrates that organisational integration alone is insufficient to achieve preventative outcomes. Effective prevention requires a broader

transformation in how systems operate, including shared strategic priorities, aligned funding mechanisms, workforce capability, data sharing, community capacity, and a cultural shift towards enablement and person-centred practice. Without these elements, integrated systems can continue to function in predominantly reactive ways.

Northern Ireland also faces several contextual challenges relevant to prevention-focused reform. These include increasing demand for social care, workforce pressures across domiciliary and community care services, regional inequalities in access to support, and continuing pressures on hospital capacity and delayed discharge. At the same time, Northern Ireland benefits from strong community and voluntary sector networks, established integrated structures, and growing policy recognition of the importance of prevention and early intervention.

1.3 Aim of the Review

The review seeks to provide a robust and accessible synthesis of current evidence relating to prevention and early intervention in adult social care, drawing on literature, policy developments, and examples of practice from Northern Ireland, the wider United Kingdom, and comparable international systems.

Specifically, the review aims to:

- Examine how prevention and early intervention are conceptually defined and operationalised across different systems and policy contexts
- Assess the effectiveness of different preventative models and approaches within adult social care
- Identify the factors that enable or inhibit successful implementation of prevention-focused approaches
- Explore how outcomes relating to prevention and independence are measured and evaluated
- Identify transferable learning from international evidence and practice relevant to Northern Ireland

- Inform the development of a practical and evidence-informed framework for prevention and early intervention within Northern Ireland’s integrated health and social care system

1.4 Policy Context in Northern Ireland

In March 2026, the Department of Health published a 10-Year Strategic Plan for Adult Social Care Reform, setting out a long-term vision for the transformation of adult social care services across Northern Ireland (Department of Health, 2026a). The strategy recognises that existing models of care are increasingly unsustainable and emphasises the need to move towards more preventative, person-centred, and community-based approaches.

The strategic plan identifies six core priorities:

- Placing citizens at the centre of care and support
- Supporting unpaid carers
- Strengthening prevention and early intervention
- Reforming home care and care home provision
- Investing in the social care workforce
- Improving long-term sustainability and resilience across the system

Supporting the long-term strategy is a three-year Delivery Plan (2025–2028), which outlines a programme of reform actions and implementation priorities agreed through the Social Care Collaborative Reform Board (Department of Health, 2026b). Central to this reform agenda is the ambition to shift care “left” — moving support closer to home and reducing reliance on hospital-based and crisis-driven models of care.

This ambition is reflected in the department’s emerging Neighbourhood Model of Health and Wellbeing, which seeks to strengthen integrated, community-based approaches to care delivery (Department of Health, 2026d). Within this wider programme of reform, the development of a comprehensive preventative adult social care framework has been identified as a key strategic priority.

1.5 Commission and Scope of the Review

This review was commissioned to support the development of a prevention and early intervention framework for adult social care in Northern Ireland. The review is intended to provide an evidence-informed foundation for policy development, strategic planning, and future service transformation.

The scope of the review includes:

- Examination of peer-reviewed academic literature and relevant grey literature
- Analysis of preventative models and approaches within adult social care
- Review of policy developments and international practice examples
- Identification of implementation enablers, barriers, and system learning
- Consideration of person-centred and system-level outcomes associated with prevention

The review draws on evidence from Northern Ireland where available, alongside literature and practice examples from England, Scotland, Wales, Ireland, Scandinavia, Australia, Canada, and the Netherlands.

Methodologically, this review represents a rapid evidence synthesis rather than a full systematic review. While every effort has been made to ensure breadth and relevance, limitations include variability in definitions of prevention across the literature, differences in international systems and contexts, and limited long-term evaluative evidence for some preventative interventions.

1.6 Structure of the Report

The remainder of this report is structured as follows:

Section 2 outlines the methodology. Section 3 provides working definitions for the Northern Ireland framework. Section 4 presents international evidence. Section 5 examines how success is measured. Section 6 identifies enablers and barriers. Section 7 translates learning into recommendations for Northern Ireland. Section 8 identifies evidence gaps. Section 9 concludes.

2. Methodology

2.1 Review Approach: Rapid Evidence Synthesis

This evidence review adopts a rapid evidence synthesis methodology to provide a robust and policy-relevant assessment of current evidence within a timeframe aligned to the Department of Health’s adult social care reform programme. While systematic reviews remain the recognised gold standard for evidence appraisal, the pace of policy development requires a more agile and applied approach. Rapid evidence synthesis is increasingly recognised as an appropriate method for informing policy decisions where timely access to evidence is required, provided that the process remains transparent and systematic (Varker et al., 2015; Tricco et al., 2017).

The review was designed to balance breadth of international evidence with practical relevance to the Northern Ireland context. In addition to identifying theoretical approaches to prevention, the review also examined implementation realities — specifically how prevention and early intervention are operationalised in practice, the conditions under which they succeed, and the barriers that frequently limit impact.

To achieve this, the review combined peer-reviewed academic evidence with policy documents, implementation reports, government evaluations, and grey literature from recognised health and social care organisations. This reflects the nature of the adult social care evidence base, where many innovations and reforms are documented through policy and practice literature rather than solely through academic publication.

2.2 Search Strategy and Information Retrieval

A structured search of peer-reviewed and grey literature was undertaken between March and May 2026. Searches were conducted across academic databases including Scopus, Web of Science, PubMed, and Google Scholar. These were supplemented by targeted searches of international policy and research repositories, including the OECD, the World Health Organization (WHO), and the European Social Policy Network.

Additional searches were undertaken across specialist social care and health policy organisations, including the Social Care Institute for Excellence (SCIE), The King’s

Fund, the Health Foundation, the Nuffield Trust, and the Canadian Foundation for Healthcare Improvement, to capture implementation learning and practice-based evidence.

Search terms combined concepts associated with prevention and early intervention — including “prevention,” “early intervention,” “reablement,” “restorative care,” and “proactive care” — with terms relating to adult social care and long-term support, such as “adult social care,” “community care,” “frailty,” “older people,” and “disability support.”

The search process was iterative. As particular interventions or policy approaches emerged within the literature, additional targeted searches were undertaken to identify evaluations and implementation evidence relating to those models.

2.3 Selection of Jurisdictions

Jurisdictions were selected on the basis of their relevance to Northern Ireland’s integrated health and social care (HSC) system, the maturity of their prevention-focused reforms, and the potential for transferable learning.

- England, Scotland, and Wales were included because they share broad legislative and institutional similarities with Northern Ireland while pursuing distinct approaches to social care reform and prevention.
- Scandinavian countries — particularly Denmark, Norway, and Sweden — were selected due to their long-standing commitment to prevention, reablement, and ageing in place. Denmark, in particular, is recognised internationally for its legislated restorative care model and preventative home visiting programmes.
- Australia was included because of its extensive reforms to aged care and disability services, including the Aged Care Act 2024 and reforms associated with the National Disability Insurance Scheme (NDIS).
- Canada was selected as a particularly relevant comparator due to its devolved and regionally administered approach to health and social care delivery. Provincial models such as Ontario Health Teams provide useful insight into integrated care, workforce investment, and community-based prevention.

2.4 Inclusion and Exclusion Criteria

The review applied defined inclusion and exclusion criteria to ensure the evidence remained focused and relevant to the development of a prevention-focused adult social care framework for Northern Ireland.

Included literature focused on adult social care, long-term care, community support, or disability services for adults and examined prevention, early intervention, reablement, restorative care, or related preventative approaches. Publications were limited to material produced between January 2015 and May 2026 to ensure contemporary relevance.

The review excluded literature focused solely on acute clinical interventions without a clear social care or community support dimension. Literature relating exclusively to children’s services was also excluded, except where findings were directly relevant to transitions into adult services. Commentary pieces lacking empirical, evaluative, or policy content were similarly excluded.

2.5 Data Extraction and Thematic Synthesis

Evidence was analysed using the thematic synthesis approach developed by Thomas and Harden (2008). This method enabled the integration of diverse forms of evidence, including academic studies, implementation evaluations, policy documents, and grey literature.

The analysis involved detailed coding of included literature to identify recurring concepts, interventions, implementation mechanisms, and outcomes. Codes were then grouped into broader themes, including reablement and restorative care, workforce capability, integration and coordination, funding and commissioning mechanisms, and community-based prevention.

The final stage of analysis focused on identifying the mechanisms and conditions associated with successful implementation and considering how international learning could be translated into Northern Ireland’s integrated HSC context.

Alongside thematic synthesis, examples of practice and international case studies were extracted to illustrate implementation approaches and common operational challenges.

2.6 Quality Assurance and Limitations

Priority was given to peer-reviewed academic literature, official government publications, and evaluations produced by recognised research and policy organisations. Grey literature was included where it provided significant implementation insight or policy learning not yet reflected within academic publications.

Several limitations should be acknowledged.

- First, this review represents a rapid evidence synthesis rather than a full systematic review, meaning some relevant literature may not have been identified within the available timeframe.
- Second, searches were limited to English-language publications, potentially excluding relevant Scandinavian or French-language Canadian evidence.
- Third, international findings cannot be transferred directly without consideration of contextual differences in governance, funding arrangements, workforce models, and culture. Approaches shown to be effective elsewhere may therefore require adaptation for Northern Ireland.
- Finally, while evidence relating to interventions such as reablement is relatively well developed, the evidence base for broader preventative approaches — particularly community wellbeing and social connectedness interventions — remains more limited and variable across jurisdictions.

3. Defining Prevention and Early Intervention

3.1 Introduction

Clear definitions are essential for coherent policy design, consistent implementation, and meaningful evaluation. In the absence of agreed conceptual boundaries, “prevention” risks becoming a broad aspirational term rather than an operational

framework capable of guiding commissioning, workforce practice, and investment decisions (Godfrey, 2001; Verity et al., 2022).

This section establishes the conceptual foundations for the proposed adult social care prevention and early intervention framework for Northern Ireland. It outlines the prevention continuum as the organising structure for the framework, distinguishes prevention from early intervention, and examines how preventative activity is operationalised across adult social care systems. The section also considers the tension between economic and wellbeing-based framings of prevention before proposing a set of working definitions for use across policy and practice in Northern Ireland.

3.2 The Challenge of Defining Prevention in Social Care

A consistent finding across the literature is the absence of a single, universally accepted definition of prevention within adult social care (Skills for Care 2019; Tew et al. 2019; Marczak et al. 2019). Prevention has frequently been described as “extremely slippery” (Godfrey, 2001), encompassing a wide range of activities that can include community wellbeing initiatives, hospital avoidance programmes, reablement services, falls prevention, social prescribing, and broader public health interventions.

Unlike traditional public health models, which often focus on preventing identifiable diseases or risk factors, adult social care prevention operates within a far more complex social context. Care needs are shaped not only by illness or disability, but also by poverty, housing, loneliness, frailty, caring responsibilities, and wider social inequalities (Verity et al., 2022). As a result, prevention within social care cannot simply be transposed from medical or public health frameworks without adaptation.

The lack of conceptual clarity has practical consequences. Keemink et al. (2023) observed that the diversity of preventative interventions across the literature makes it difficult to robustly assess impact or compare outcomes across systems. Without clearer definitions, prevention risks remaining rhetorically important but operationally inconsistent.

For Northern Ireland, establishing a shared and practical understanding of prevention will therefore be fundamental to the development of a coherent and implementable framework.

3.3 The Prevention Continuum: Upstream to Downstream

The organising framework adopted within this review is the three-tier prevention continuum as proposed by SCIE (2021). This model distinguishes interventions according to when they occur in relation to the onset or escalation of care needs.

Primary prevention refers to universal, population-level activity intended to prevent care and support needs from arising in the first place. These interventions are generally delivered through public health, community, and voluntary sector approaches and focus on promoting wellbeing, healthy ageing, social participation, and independence. Examples include community exercise programmes, social connection initiatives, accessible information and advice, and “warm home” schemes.

Secondary prevention focuses on individuals or groups at increased risk of deterioration. The aim is to identify emerging need early and intervene before escalation occurs. Examples include frailty screening, falls prevention pathways, targeted support for unpaid carers, and proactive multidisciplinary interventions delivered through integrated community teams.

Tertiary prevention refers to restorative activity aimed at minimising the impact of established care needs and preventing further decline. Within adult social care, this is most closely associated with reablement and rehabilitation services. The focus is on restoring or maximising independence following illness, injury, hospital admission, or functional deterioration.

Together, these three levels represent a continuum rather than separate or isolated interventions. Effective prevention-focused systems require activity across all three tiers simultaneously.

3.4 Distinguishing Prevention from Early Intervention

Although **prevention** and **early intervention** are often used interchangeably within policy discourse, they are not synonymous.

- **Prevention** is the broader umbrella concept encompassing all activity intended to stop care needs from arising, escalating, or worsening. It spans primary, secondary, and tertiary prevention.
- **Early intervention** is more specific and sits primarily within the secondary prevention tier. Its defining feature is timeliness — identifying and responding to emerging need at the earliest possible stage to avoid deterioration, crisis, or the requirement for intensive support.

This distinction has practical implications for policy and service delivery. Universal wellbeing initiatives, targeted risk identification, and restorative reablement interventions require different delivery models, workforce skills, and outcome measures. Clear differentiation also supports more effective resource allocation and evaluation across the system.

3.5 Operationalising Prevention: Universal, Targeted, and Reablement Approaches

The literature broadly identifies three operational forms of preventative activity within adult social care systems.

Universal prevention corresponds to primary prevention and is directed at the whole population regardless of risk level. These approaches are intended to strengthen resilience, wellbeing, and social participation at a population level. Although their impact can be difficult to measure in the short term, they form a critical foundation for asset-based and community-focused prevention strategies (Verity et al., 2022).

Targeted prevention corresponds to secondary prevention and focuses on individuals identified as being at heightened risk of deterioration. This requires systems capable of identifying risk through professional judgement, data-driven risk stratification, or validated screening tools. Keemink et al. (2023) found that targeted interventions linked to specific pathways, such as frailty or falls prevention services, generally demonstrated stronger outcomes than more generic preventative approaches.

Reablement corresponds to tertiary prevention and is increasingly recognised internationally as the core restorative response within adult social care systems.

Reablement differs from traditional maintenance home care in several important ways: it is time-limited, goal-oriented, multidisciplinary, and focused on enablement rather than dependency. The emphasis is on supporting people to regain confidence, skills, and functional independence through a “doing with” rather than “doing for” approach (Rostgaard, 2018).

Evidence from international studies suggests that reablement can improve mobility, daily functioning, quality of life, and reduce long-term reliance on care services (Welsh Government, 2021).

3.6 Economic and Wellbeing Framings

The evidence base highlights two dominant ways of framing prevention within adult social care policy.

The **economic framing** positions prevention primarily as a mechanism for reducing future demand on health and social care systems. From this perspective, investment in preventative social care is justified through its potential to reduce hospital admissions, delayed discharges, long-term care admissions, and system costs (Spiers et al., 2019).

The **wellbeing framing** places greater emphasis on autonomy, dignity, social participation, independence, and quality of life. Prevention is viewed not simply as a mechanism for reducing expenditure, but as a means of enabling people to live well and maintain meaningful lives within their communities (Verity et al., 2022).

These framings are not mutually exclusive. However, an overly narrow focus on financial savings risks undervaluing preventative interventions that produce broader social and wellbeing benefits which may be less immediately measurable. For Northern Ireland, a balanced framework will be required, one that recognises both the economic and human value of prevention.

3.7 Asset-Based and Capability Approaches

Contemporary prevention policy increasingly emphasises asset-based approaches that focus on strengths, capabilities, and community resources rather than solely on deficits or dependency.

Asset-based approaches recognise that individuals, families, communities, and voluntary organisations all contribute to wellbeing and independence. Formal services therefore represent only one part of a wider support ecosystem.

Closely linked to this is the **capability approach**, which focuses on what people can do and be, rather than simply what services they receive. From this perspective, prevention involves ensuring individuals have the freedom and opportunity to achieve outcomes they value, such as remaining in their own home, maintaining relationships, or participating in community life (Godfrey, 2001).

This perspective broadens the understanding of prevention beyond traditional service delivery and highlights the importance of housing, transport, social connection, digital inclusion, and community participation in supporting independence and wellbeing.

3.8 Addressing Social Determinants and Inequalities

The need for social care and support is not distributed equally across the population. Wider social determinants, including poverty, housing, education, employment, and social isolation have a major influence on health outcomes, disability, and care needs.

McNally (2020) highlights significant health inequalities across the UK, noting that people living in deprived areas experience illness and disability substantially earlier than those in more affluent communities. Older people in deprived areas are also considerably more likely to require support with activities of daily living.

Preventative approaches must therefore be designed with equity as a central principle. Systems that fail to account for inequality risk widening existing disparities in health and social outcomes. Effective prevention requires targeted investment, accessible services, and proactive approaches to reaching communities experiencing the greatest disadvantage.

3.9 Proposed Working Definitions for Northern Ireland

To support consistency across policy, commissioning, and practice, the following working definitions are suggested for the adult social care prevention and early intervention framework. These definitions are intended to offer a practical and shared

foundation for framework development across Northern Ireland’s health and social care system.

Term	Working Definition
Prevention	Proactive action to stop care needs from arising, escalating, or worsening across all levels of the prevention continuum.
Early Intervention	Identifying and responding to emerging needs at the earliest possible stage to prevent escalation or crisis.
Primary Prevention	Universal activity aimed at preventing the onset of care and support needs across the wider population.
Secondary Prevention	Targeted interventions for individuals or groups at increased risk of deterioration or escalating need.
Tertiary Prevention	Restorative interventions designed to minimise the impact of established needs and maximise independence.
Reablement	A time-limited, goal-oriented, multidisciplinary intervention focused on restoring or maintaining functional independence.

4. International Evidence: What Works and Why

4.1 Introduction

This section examines international evidence on prevention and early intervention in adult social care across six jurisdictions selected for their relevance to Northern Ireland: England, Scotland, Wales, Scandinavia (Denmark, Norway, and Sweden), Australia, and Canada. The purpose is not simply to describe international reforms, but to identify the specific mechanisms through which preventative systems operate and the lessons they offer for Northern Ireland’s integrated health and social care (HSC) system.

Across all jurisdictions, prevention is increasingly understood not as a standalone service, but as a redesign of how systems respond to risk, independence, and escalating need. The evidence demonstrates that successful prevention frameworks share several characteristics: clear legislative mandates, dedicated funding

mechanisms, strong community and workforce infrastructure, integrated data and assessment systems, and measurable accountability for outcomes.

The section examines each jurisdiction in turn before identifying cross-cutting themes and implications for Northern Ireland.

4.2 England: Mandated Prevention Through Funding and Regulation

England’s approach to prevention is characterised by the use of strong financial and regulatory levers to shift local systems away from crisis response and towards earlier intervention. Rather than relying solely on policy rhetoric, prevention is embedded within funding conditions, performance management, and inspection frameworks.

A central mechanism is the Better Care Fund (BCF), which pools National Health Service (NHS) and local authority resources to support integrated care. Recent reforms require increased NHS contributions to adult social care and link elements of funding to measurable outcomes such as reductions in avoidable care home admissions and delayed discharges (Department of Health and Social Care, 2026). This creates a direct incentive for local systems to invest in preventative services that reduce escalation into more intensive forms of care.

Alongside financial reform, England has strengthened regulatory accountability. The Care Quality Commission’s (CQC) revised assurance framework for local authorities explicitly assesses how councils promote independence, prevent deterioration, and support people to remain in their communities (Wenzel et al., 2026). Prevention is therefore treated not as an optional enhancement, but as a core indicator of system performance.

England has also invested heavily in digital infrastructure intended to support preventative approaches at scale. The NHS App and Federated Data Platform are designed to improve self-management, enable data sharing across organisations, and support predictive identification of people at risk of crisis (NHS England, 2025). These developments aim to create a more proactive system capable of intervening earlier. However, evidence regarding their long-term impact on preventative outcomes remains limited.

The English experience demonstrates several important policy lessons. First, prevention is more likely to become operational when embedded within funding rules and regulatory oversight rather than treated as discretionary activity. Second, outcome-focused incentives can encourage local systems to prioritise prevention, particularly where financial pressures might otherwise favour reactive responses. Third, digital infrastructure can strengthen prevention capability, but technology alone is insufficient without workforce capacity, community services, and integrated pathways capable of responding once risk is identified.

4.3 Scotland: National Mission and Technology Investment

Scotland has positioned prevention within a broader national reform agenda centred on the development of a National Care Service (NCS). Its approach combines investment in community-based alternatives to hospital care, technology enabled support, and stronger integration between primary care and social care services.

A major focus has been the expansion of “Hospital at Home” services, which provide acute-level care within people’s homes as an alternative to hospital admission. Between 2024 and 2025, these services supported almost 16,000 people to avoid hospital stays (Scottish Government, 2025). Evaluations report high levels of satisfaction alongside reduced readmissions for individuals with chronic conditions. The model demonstrates how tertiary prevention can reduce dependence on institutional care while supporting people to remain at home.

Scotland has also strengthened secondary prevention through the introduction of designated Frailty Leads within General Practice. By spring 2026, participating GP practices are expected to have named professionals responsible for identifying frailty early, coordinating assessment, and linking patients with community-based support and reablement services (Scottish Government, 2026). This embeds prevention directly within primary care rather than treating it as a separate specialist function.

These reforms are supported by substantial public investment. The Scottish Government has committed to major increases in social care spending, including funding for workforce expansion, digital infrastructure, and community service development (Scottish Government, 2025). The scale of investment reflects

recognition that preventative systems cannot be delivered through structural reform alone.

Scotland’s experience illustrates several important lessons. First, prevention requires visible national leadership and a clear strategic narrative rather than isolated pilot schemes. Second, primary care plays a critical role in identifying risk early and coordinating preventative responses. Third, technology enabled care can support prevention when integrated into wider pathways of care. Finally, sustained financial investment is essential if preventative ambitions are to move beyond policy aspiration.

4.4 Wales: Statutory Partnerships and Regional Delivery

Wales has pursued prevention primarily through legislative integration and regional partnership structures. The Social Services and Well-being (Wales) Act 2014 established a statutory duty on local authorities and health boards to work together to prevent and delay the development of care and support needs (Welsh Government, 2014). Prevention is therefore embedded within the legal architecture of the system itself.

This duty is operationalised through seven Regional Partnership Boards (RPBs), which bring together local authorities, health boards, housing organisations, and third sector representatives on a statutory basis (Welsh Government, 2024). Unlike voluntary collaborative arrangements, the RPB model creates formal accountability for joint planning and service delivery across organisational boundaries.

The RPBs are responsible for producing regional population needs assessments and integrated area plans, with prevention and early intervention forming core priorities. They also oversee the Intermediate Care Fund (ICF), a dedicated funding stream used to support preventative initiatives such as rapid response services, reablement teams, community coordination programmes, and integrated discharge pathways (Welsh Government, 2025).

Wales is also introducing national service frameworks for frailty and dementia, intended to standardise preventative practice and establish consistent expectations across regions (Welsh Government, 2026). These frameworks aim to reduce variation in access, assessment, and intervention.

The Welsh model highlights several policy lessons. First, statutory partnership arrangements create stronger accountability for prevention than voluntary collaboration alone. Second, regional governance structures can support integrated planning across health, housing, and social care systems. Third, prevention requires dedicated funding streams capable of supporting innovation and service redesign. Finally, national service frameworks can help reduce variation and create clearer expectations regarding preventative practice.

4.5 Scandinavia: Legislated Reablement and Preventive Outreach

The Scandinavian countries, particularly Denmark, Sweden, and Norway provide some of the strongest international examples of prevention-oriented social care systems. Although each country has distinct arrangements, all share a commitment to universalism, ageing in place, reablement, and early preventative intervention embedded within municipal systems.

Denmark represents perhaps the clearest example of legislated reablement. Since 2015, municipalities have been legally required to assess whether an individual could benefit from reablement before approving permanent long-term care (Rostgaard, 2018). Reablement is therefore positioned as the default response rather than an optional service. The model is multidisciplinary, goal-oriented, and time-limited, typically lasting between two and twelve weeks. It is explicitly built around the principle of “doing with” rather than “doing for.”

Denmark also operates a national preventive home visit programme for older people. Citizens aged 82 years and over are offered annual visits focused on wellbeing, housing, social participation, and functional ability (Rostgaard & Graff, 2025). These visits aim to identify risks early before deterioration becomes severe. Research involving more than 3,000 older adults found that visits conducted by specially trained staff were associated with a 34 per cent reduction in progressive functional decline.

A further defining feature of the Danish model is its long-standing commitment to deinstitutionalisation. Since 1987, Denmark has prioritised supported housing and community-based care over traditional nursing home expansion (Rostgaard et al.,

2022). This reflects a broader policy philosophy that independence and home-based living should be the norm wherever possible.

Sweden has developed innovative municipal prevention models. Härnösand Municipality established a mobile multi-professional Assessment and Intervention Team in response to projected demographic pressures (Interreg Europe, 2025). The team identifies older people with rehabilitation potential and delivers preventative home-based interventions. Reported outcomes included reductions in home care dependency, significant improvements in independence, and high levels of service-user involvement.

Swedish municipalities are also required to provide preventive home visits to older residents, reinforcing the importance of early identification and proactive outreach (Swedish National Board of Health and Welfare, 2022). More broadly, Sweden’s eldercare system strongly prioritises home-based support over institutional placement.

Norway has implemented a similar approach through “hverdagsrehabilitering” (everyday rehabilitation), a municipal reablement model involving occupational therapists, physiotherapists, nurses, and care staff working collaboratively to restore functional ability (Kjelvik & Söderberg, 2020). Like the Danish model, interventions are time-limited, goal-focused, and centred on independence.

The Scandinavian experience offers several significant lessons. First, prevention is strongest where reablement is embedded as a routine expectation rather than a discretionary service. Second, preventative outreach through home visits can support earlier identification of risk and reduce long-term deterioration. Third, multidisciplinary working is central to effective reablement. Finally, these systems demonstrate the importance of aligning housing, community support, and social care policy around the principle of ageing in place.

4.6 Australia: Prevention Built into National Scheme Design

Australia provides an example of prevention being incorporated into large-scale national system reform. Recent reforms in aged care and disability services aim to embed earlier intervention, restorative care, and independence within eligibility systems, assessment models, and regulatory frameworks.

The Aged Care Act 2024 establishes a new rights-based framework for aged care and replaces a fragmented legislative system (Australian Government Department of Health and Aged Care, 2025). Central to these reforms is the “Support at Home” programme, introduced nationally from late 2025. The programme is explicitly designed to help older people remain independent for longer and avoid premature entry into residential care.

Support is organised through tiered packages linked to assessed levels of need, with a strong emphasis on restorative care and reablement. The reform therefore shifts the system away from passive maintenance models towards interventions intended to preserve or restore functional capacity.

Australia is also strengthening regulation and quality assurance. A new regulatory framework commencing in 2026 introduces universal provider registration and government-set pricing arrangements aimed at improving consistency, oversight, and accessibility.

Alongside aged care reform, the National Disability Insurance Scheme (NDIS) is introducing structured needs-based planning models to support earlier and more consistent identification of support requirements. The expansion of “foundational supports” outside the full NDIS scheme also reflects an attempt to intervene earlier for people with lower or emerging levels of need (NDIS Review, 2023).

Australia’s reforms illustrate several lessons for prevention policy. First, prevention can be embedded directly within assessment systems and eligibility criteria rather than added retrospectively. Second, rights-based approaches can strengthen the focus on independence and autonomy. Third, large-scale reform requires strong implementation planning and sustained political commitment. Finally, preventative ambition must be supported by regulatory systems capable of ensuring consistency and quality across providers.

4.7 Canada: Integrated Care, Community Innovation, and Workforce Investment

Canada provides important examples of prevention emerging through provincial innovation within a broader federal framework. Approaches vary significantly across

provinces, but common themes include integrated care, workforce investment, ageing in place, and community-based support (Marchildon et al., 2021).

Ontario Health Teams (OHTs) are among the most significant recent reforms. Introduced in 2019, OHTs bring together health, social care, and community organisations within integrated local networks (Farhana et al., 2025). Their long-term aim is to create coordinated systems accountable for population health outcomes rather than fragmented organisational performance (Embuldeniya et al., 2021).

The Ontario Health Team of Northumberland demonstrates how integrated structures can support prevention-focused priorities. Its strategic plan focuses on helping older adults with complex needs remain at home and improving care coordination for rural populations facing barriers to access (Ontario Health Team of Northumberland, 2026).

Canada has also invested in collaborative learning structures. The Ontario Collaborative for Aging Well (OCAW) brings together providers, networks, and community organisations to share preventative practice, particularly in areas such as dementia care, caregiver support, integrated primary care, and ageing-friendly communities (Kay & Webster, 2026).

New Brunswick has taken a different but equally important approach through major workforce and home-care investment. Its “Stronger Care for Seniors” strategy is supported by almost \$1 billion in funding and focuses on workforce stability, community support, home care affordability, and ageing in place (Dupuis-Blanchard, 2025). Investments include wage increases for care workers, expanded home support subsidies, and growth of the “Nursing Home Without Walls” programme (Dupuis-Blanchard et al, 2018).

Several innovative community-based programmes also offer transferable lessons. The SMILE programme supports older people at risk of losing independence through practical home-based services including transport, meals, respite, and household support (VON Canada, 2025). Meanwhile, the CAPABLE programme combines occupational therapy, nursing support, assistive technology, and home modifications to improve functional independence. Evaluations have reported improvements in daily living activities and reduced depressive symptoms.

Canada has additionally recognised workforce protection as part of prevention infrastructure. Ontario’s expansion of mandatory workplace insurance coverage to frontline care workers reflects growing recognition that prevention depends on a stable, supported workforce capable of sustaining relational continuity in care (Government of Ontario, 2026).

The Canadian experience highlights several lessons. First, integrated care structures can support prevention when linked to shared accountability and population-level outcomes. Second, workforce investment is a core prevention strategy rather than a separate workforce issue. Third, practical home-based supports can significantly delay deterioration and institutional care. Finally, local innovation can flourish within broader strategic frameworks when systems are given flexibility to adapt services to local populations.

4.8 Emerging Themes

Several consistent themes emerge across the international evidence despite differences in welfare systems, governance structures, and funding models.

First, prevention is most effective when embedded within legislation, funding arrangements, and accountability systems rather than treated as policy rhetoric. England links funding to preventative outcomes through the Better Care Fund, Denmark legally requires reablement assessment before permanent care is approved, and Wales places prevention within statutory partnership duties. These examples demonstrate that prevention becomes operational when it is built into the rules of the system through mandatory duties, dedicated funding, and measurable performance expectations.

Second, integration is necessary but insufficient on its own. Wales’s Regional Partnership Boards and Ontario Health Teams show that structural integration creates the conditions for prevention but does not automatically produce preventative practice. Effective systems also require aligned incentives, shared pathways, coordinated budgets, interoperable data systems, and clear operational responsibilities. The Scandinavian evidence further demonstrates that integration must exist at frontline practice level through multidisciplinary teams, not simply at organisational level.

Third, reablement is most effective when treated as the default response to functional decline rather than a specialist or discretionary service. Scandinavian systems demonstrate a clear shift from maintenance models toward enablement and restoration. Successful reablement services are consistently multidisciplinary, time-limited, goal-oriented, and focused on restoring independence within the home environment. Evidence suggests this approach can reduce long-term care dependency, delay residential care admission, and improve functional outcomes.

Fourth, early identification and proactive outreach are central to effective prevention. Scotland’s Frailty Leads, Scandinavian preventive home visits, and England’s predictive data systems all aim to identify deterioration before crisis occurs. However, the evidence also shows that early identification is ineffective unless responsive services exist to intervene quickly once risk is identified.

Fifth, workforce capacity is fundamental to prevention. Preventative systems depend on continuity of relationships, skilled assessment, multidisciplinary working, and personalised support. International evidence consistently shows that prevention cannot succeed without workforce investment, including recruitment, retention, training, and professional development. Reablement and asset-based approaches also require cultural change, moving staff away from “doing for” toward enabling independence.

Sixth, prevention requires sustained investment and long-term political commitment. Most preventative interventions take time to produce measurable reductions in crisis demand. Short-term funding cycles therefore undermine prevention by encouraging systems to prioritise immediate pressures over longer-term transformation. International evidence suggests that stable funding, long-term planning, and protected prevention budgets are essential for meaningful reform.

Finally, the evidence highlights the importance of broader outcome measurement. Prevention should not be evaluated solely through hospital admissions or delayed discharges. Scandinavian and Canadian approaches place greater emphasis on independence, wellbeing, quality of life, participation, and social connectedness. This

reflects a broader shift from viewing prevention purely as demand management toward understanding it as support for autonomy and capability.

4.9 Implications for Northern Ireland

The international evidence has several important implications for Northern Ireland.

First, Northern Ireland’s integrated HSC system provides a structural advantage that many jurisdictions lack. However, international evidence demonstrates that organisational integration alone does not create preventative systems. Integration must be operationalised through shared prevention priorities, aligned funding mechanisms, multidisciplinary locality working, and accountability frameworks focused on preventative outcomes.

Second, prevention must be embedded formally within policy, funding, and regulation. International examples consistently show that prevention remains vulnerable when treated as discretionary activity. Northern Ireland should therefore consider stronger statutory duties, dedicated prevention funding, and performance frameworks that explicitly measure independence, enablement, and prevention of escalation.

Third, the evidence strongly supports repositioning reablement as the default response to functional decline. Scandinavian systems demonstrate that this changes the orientation of care from maintenance toward restoration and independence. Achieving this would require stronger therapy capacity, multidisciplinary teams, workforce training in enablement approaches, and consistent regional pathways.

Fourth, preventive home visits and structured frailty pathways warrant consideration in Northern Ireland. The Scandinavian and Scottish evidence suggests that proactive identification models can intervene earlier and reduce deterioration before crisis develops. Any such initiatives should be rigorously evaluated using both economic and wellbeing measures.

Fifth, workforce reform must be understood as a prevention issue rather than a separate workforce agenda. Prevention depends on relational continuity, professional skill, and multidisciplinary collaboration, all of which require sustained workforce investment.

Finally, the evidence demonstrates that prevention is a long-term transformation agenda rather than a short-term efficiency programme. Meaningful reform requires sustained political commitment, stable investment, phased implementation, and cultural change across the Health and Social Care system.

5. How Success is Measured

5.1 Introduction

A prevention-focused framework is only as credible as its measurement approach. Without robust and transparent data, prevention risks remaining an aspirational concept rather than an evidence-informed strategy. International experience demonstrates that jurisdictions making the greatest progress in prevention have also invested heavily in measurement systems capable of tracking both citizen outcomes and system performance over time.

The challenge is particularly acute in adult social care because preventative interventions often produce diffuse, long-term, and multi-dimensional outcomes. Unlike acute healthcare, where success can be measured through discrete clinical events, prevention in social care involves tracking functional independence, wellbeing, social connection, delayed deterioration, and avoidance of crisis. Effective measurement frameworks must therefore move beyond narrow hospital metrics to capture broader quality-of-life outcomes while still demonstrating value for money.

This section examines how leading jurisdictions measure prevention and early intervention. It focuses on Denmark’s national indicator framework, Sweden’s real-time quality registers, England’s regulatory benchmarking approach, and lessons from Canada and Australia regarding equity and algorithmic assessment. It then identifies principles that should underpin a Northern Ireland measurement framework.

5.2 Denmark: National Prevention Indicators

Denmark demonstrates how prevention can be embedded within national statistical infrastructure rather than treated as a separate policy initiative. Prevention metrics are incorporated into routine data collection systems, enabling municipalities and national government to monitor functional outcomes with the same level of scrutiny applied to hospital activity (Kvist, 2018).

A key strength of the Danish approach is the distinction between outcome indicators and process indicators (Vass et al., 2007). Outcome indicators focus on the impact experienced by the individual, including rates of hospital admission, average hospital days for older adults, continuity of care, and the extent to which individuals maintain independence at home (Hendriksen & Vass, 2021). Process indicators track the activities undertaken by the system itself, such as the number of preventive home visits completed, uptake of reablement services, and rehabilitation completion rates (Rostgaard, 2024).

This distinction is important because it prevents systems from measuring activity alone. A high number of assessments or home visits does not necessarily indicate successful prevention unless it translates into improved outcomes for citizens (Vass et al., 2007). Denmark’s framework therefore links operational activity directly to measurable functional trajectories over time.

The Danish system also benefits from national consistency. Municipalities operate locally but report against common indicators, enabling benchmarking across the country. This creates accountability while still allowing flexibility in local delivery models (Rostgaard, 2024).

The wider policy lesson is that prevention measurement must be integrated into mainstream performance management systems. If prevention indicators sit outside core accountability structures, they are unlikely to influence organisational behaviour or funding decisions (Olejz et al., 2012).

5.3 Sweden: Senior Alert and Real-Time Monitoring

Sweden operates a highly decentralized health and social care system where responsibility is shared between 21 regions (primarily responsible for healthcare) and 290 municipalities (responsible for social care and housing) (Anell et al., 2012). Within this structure, Sweden’s approach to prevention is heavily data-driven, supported by national policy and specialized infrastructure.

A cornerstone of Sweden’s preventive strategy is its system of National Quality Registries. Among these, the Senior Alert registry is unique in focusing explicitly on preventive care rather than specific diseases (Edvinsson et al., 2015). Senior Alert tracks and supports preventive processes for older adults across four primary risk areas: falls, pressure ulcers, malnutrition, and poor oral health (Fagerström et al., 2017). The registry relies on a structured, four-step preventive care model: standardized risk assessment, team-based analysis of underlying causes, planning and performance of care interventions, and subsequent evaluation (Edvinsson et al., 2015).

The registry facilitates preventative care by prompting healthcare workers to carry out timely interventions when risks are identified—such as dietary support or weight control for individuals flagged as being at risk of malnutrition (Backlund et al., 2018). Senior Alert is widely utilized across both municipal care and regional health services, providing real-time data that allows local care units and national policymakers to monitor adherence to evidence-based preventive guidelines (Edvinsson et al., 2015).

Sweden has also prioritized health promotion and secondary prevention through specialized local structures. Health Guidance Centres (Hälsotorg), often located within or alongside primary care clinics, offer accessible, community-based support for lifestyle modifications. These centres provide individual counselling, health educational materials, and targeted interventions for physical activity, smoking cessation, and stress management, aiming to mitigate chronic disease risk before intensive medical intervention is required (Nilsen et al., 2011).

Furthermore, Sweden has institutionalized Physical Activity on Prescription (FaR - Fysisk aktivitet på recept) within its primary care framework (Kallings, 2011). Under

this scheme, licensed healthcare professionals prescribe tailored physical activity as a formal method of prevention or treatment for various non-communicable conditions, such as hypertension or type 2 diabetes, leveraging community-based sports and exercise facilities to support long-term adherence (Onerup et al., 2019).

The Swedish experience offers key insights into structural prevention. First, integrating standardized risk screening into routine care via national registries like Senior Alert establishes visible, measurable accountability for preventative outcomes. Second, bridging regional healthcare with municipal social services requires clear, data-driven frameworks to prevent fragmented care delivery. Finally, embedding lifestyle interventions directly into primary care through structured mechanisms like prescribing physical activity transitions prevention from a generalized goal into an actionable clinical practice.

5.4 Canada and Australia: Equity, Workforce, and Algorithmic Risk

Canada and Australia provide important lessons regarding the broader dimensions of prevention measurement, particularly equity, workforce sustainability, and the risks associated with automated assessment systems.

In Canada, several provincial frameworks increasingly recognise that preventative systems cannot be evaluated solely through service utilisation metrics (Embuldeniya et al., 2021). Ontario’s integrated care initiatives include indicators linked to equity, access, caregiver wellbeing, and workforce participation. This reflects an understanding that prevention outcomes are shaped by social inequalities, workforce stability, and continuity of relationships as much as by clinical interventions (Farhana al., 2025).

Canadian approaches also place greater emphasis on caregiver outcomes. Measures increasingly include caregiver stress, burnout, and confidence in managing care at home. This is significant because unpaid carers are often central to preventing escalation into formal services (Ontario Caregiver Organization, 2024).

Australia provides a more cautionary example. Reforms linked to the Aged Care Act and disability assessment systems have involved growing use of structured and algorithmic assessment tools to determine eligibility and funding allocation. While intended to improve consistency, concerns have emerged regarding transparency, bias, and the inability of automated systems to account for complexity or contextual nuance.

Investigations by oversight bodies highlighted concerns that algorithmic approaches may compound existing inequalities if individuals with complex social needs are not adequately recognised within standardised scoring systems. The Australian experience therefore demonstrates that data-driven prevention systems must retain professional judgement and clear avenues for human review.

Together, the Canadian and Australian experiences highlight that prevention measurement is not only a technical exercise. It is also a question of ethics, fairness, transparency, and trust.

5.5 Towards a Measurement Framework for Northern Ireland

The international evidence suggests that effective prevention measurement frameworks share several common characteristics. First, they distinguish between process measures and outcome measures. Systems must track both what services do and whether those actions improve people’s lives.

Second, successful frameworks combine quantitative and qualitative evidence. Administrative data alone cannot capture independence, confidence, social connectedness, or wellbeing. User-reported outcomes and experience measures are therefore essential.

Third, measurement begins early. Jurisdictions such as Sweden demonstrate the value of identifying risk before crisis occurs rather than measuring prevention retrospectively through hospital admissions alone (Edvinsson et al., 2015).

Fourth, prevention metrics must operate across organisational boundaries. Effective prevention involves health services, social care, housing, voluntary organisations, and unpaid carers. Measurement systems must therefore support integrated accountability rather than reinforcing organisational silos.

Fifth, workforce metrics matter. Stable staffing, continuity of care, training levels, and staff wellbeing are increasingly recognised internationally as prevention enablers rather than separate workforce issues.

Finally, transparency is essential. Measurement systems must be understandable, proportionate, and open to scrutiny if they are to command public and professional confidence.

5.6 Implications for Northern Ireland

For Northern Ireland, the evidence points toward the need for a unified prevention measurement framework operating across the health and social care system. Such a framework should combine population-level indicators, service performance metrics, and citizen-reported outcomes within a single integrated structure.

A core priority should be the introduction of standardised assessment tools across all five trusts to support consistency in identifying frailty, functional decline, and rising risk. This would enable comparable data collection and strengthen the ability to evaluate preventative interventions at regional level.

Northern Ireland should also avoid relying solely on hospital-based indicators as proxies for prevention success. While reductions in admissions and delayed discharges remain important, they capture only part of the preventative picture. Measures relating to independence, quality of life, caregiver wellbeing, social connectedness, and continuity of care must also be incorporated.

The international evidence further suggests that prevention metrics should be embedded within accountability and funding arrangements rather than operating as

standalone reporting exercises. Without this integration, prevention risks becoming secondary to short-term crisis management pressures.

Finally, Northern Ireland should adopt a cautious and transparent approach to digital and algorithmic assessment tools. Technology can strengthen prevention through earlier identification and improved data sharing, but professional judgement and human oversight must remain central to decision-making processes.

By establishing a robust measurement framework at the outset, Northern Ireland can move prevention from policy aspiration to measurable system transformation, supported by evidence demonstrating both improved citizen outcomes and reduced reliance on crisis-driven care.

6. Enablers and Barriers to Implementation

6.1 Introduction

The transition to a prevention-first model in adult social care is frequently described as a process of “shifting the centre of gravity” of the system away from reactive crisis management and toward earlier, strengths-based intervention. International evidence demonstrates that this shift is not achieved through a single reform or policy announcement. Rather, it requires sustained alignment across funding, workforce development, leadership, regulation, data infrastructure, and community engagement.

This section examines the principal enablers and barriers influencing implementation. It draws on evidence from the UK and international literature to explore why prevention strategies frequently fail to translate into front-line practice, despite broad policy consensus regarding their importance.

6.2 The Policy–Practice Gap

A consistent finding across the literature is the gap between prevention as a policy aspiration and prevention as an operational reality. Needham and Hall (2023) argue that despite prevention being embedded within the statutory duties of the Care Act

2014 in England, tangible improvements for communities remain limited. Prevention is often rhetorically prioritised while resources continue to flow disproportionately toward acute and crisis responses.

This reflects a wider structural problem within health and social care systems. Preventative interventions typically require long-term investment, while political and financial cycles remain short-term. The benefits of prevention, such as delayed residential care admission, reduced frailty progression, or sustained independence, often emerge over several years rather than within a single budget cycle (Future of Prevention, 2025). Consequently, systems under immediate operational pressure frequently redirect preventative funding toward urgent demand management.

The literature also highlights a cultural dimension to the policy–practice gap. Deficit-based models remain deeply embedded within many services, particularly where workforce pressures incentivise task completion over relational and restorative approaches (Rostgaard, 2018). As a result, prevention can become reduced to isolated projects rather than a system-wide philosophy shaping assessment, care planning, and service delivery.

6.3 National Enablers: Creating the Conditions for Prevention

International evidence demonstrates that successful prevention systems require strong national infrastructure and policy alignment. Countries that have made sustained progress on prevention have generally combined legislative commitment with long-term investment and robust accountability frameworks. Three national enablers emerge consistently within the literature.

First, long-term and ring-fenced investment is essential. Prevention programmes require sustained funding to allow services to mature and demonstrate impact. Short-term pilot funding frequently undermines continuity, workforce retention, and evaluation capacity (Future of Prevention, 2025; Humphries et al, 2016). Scotland’s multi-year social care investment programme and Denmark’s sustained municipal investment in reablement (Rostgaard, 2018) illustrate the importance of predictable funding environments.

Second, data interoperability and national standards are critical. Preventative systems depend on the ability to identify individuals at rising risk before crisis occurs. This requires integrated health and social care data systems capable of supporting population health management, frailty identification, and predictive analytics (NHS England, 2025). Fragmented data systems limit early intervention because practitioners are unable to develop a shared view of need across organisational boundaries.

Third, regulatory alignment plays a significant role in shaping organisational behaviour. England’s Care Quality Commission framework increasingly evaluates local authorities on their ability to maintain independence and reduce avoidable deterioration (Care Quality Commission, 2024). This represents an important shift from measuring only service safety and compliance toward measuring preventative outcomes. International evidence suggests that prevention becomes operationally meaningful when it is incorporated into inspection regimes, performance management, and funding mechanisms.

6.4 Local Enablers: Translating Policy into Practice

While national policy creates enabling conditions, implementation ultimately depends on local leadership, workforce capability, and partnership working.

Strategic leadership is consistently identified as a critical success factor. Prevention requires senior leaders to frame investment in early intervention not as discretionary spending but as both a moral and financial imperative (ADASS, 2025). Where leadership commitment is weak or inconsistent, prevention activity is often deprioritised during periods of operational pressure.

Integrated governance structures also support implementation. Evidence from Wales’s Regional Partnership Boards (Chesterfield et al., 2021) and Canadian Ontario Health Teams (Farhana et al., 2025) demonstrates that formal partnership arrangements improve coordination across health, housing, social care, and voluntary sectors. However, successful integration depends not only on structural

alignment but also on shared accountability, pooled resources, and jointly agreed outcomes (Wojtak, 2026).

Workforce capability is equally important. Prevention depends heavily on relational continuity, strengths-based assessment, and early identification of subtle deterioration. Yet many systems continue to face significant workforce instability, recruitment challenges, and limited preventative training opportunities. Evidence from PA Consulting (2026) found that only 16 per cent of social care leaders believed their workforce fully understood the benefits and applications of technology enabled care (TEC). Similar gaps exist around reablement practice, strengths-based approaches, and frailty identification.

International evidence further suggests that workforce confidence is closely linked to organisational culture. Staff working within highly task-oriented systems may struggle to adopt preventative approaches where operational pressures reward throughput rather than outcomes. Sustained workforce development, supervision, and multidisciplinary collaboration are therefore central implementation requirements rather than secondary considerations.

6.5 Persistent System Barriers

Despite growing international consensus around prevention, several structural barriers continue to impede implementation.

One of the most significant barriers is the “crisis trap.” ADASS (2024) reports that 81 per cent of councils in England expected to overspend on adult social care due to escalating acute demand pressures. Under these conditions, preventative investment is often diverted toward immediate crisis response. This creates a self-reinforcing cycle in which underinvestment in prevention generates greater downstream demand.

Workforce instability represents a second major barrier. High turnover rates, vacancy pressures, and increasingly fragmented employment models undermine the relational continuity necessary for effective prevention (Skills for Care, 2024).

Preventative practice frequently relies on carers and professionals recognising gradual changes in mobility, confidence, nutrition, cognition, or social engagement over time. Fragmented staffing models reduce opportunities for these observations and weaken trust-based relationships.

A further barrier concerns conceptual inconsistency. As discussed in Section 3, prevention is frequently defined inconsistently across organisations and professions (Godfrey, 2001; Verity et al., 2022). Without shared operational definitions, services may label almost any activity as “preventative,” limiting strategic coherence and complicating evaluation.

Digital inequality also presents an emerging implementation challenge. While technology enabled care is increasingly positioned as a key prevention tool, access and digital literacy remain uneven across populations, particularly among older adults in deprived or rural communities (Fang et al, 2019). Overreliance on digital models risks reinforcing existing inequalities if implementation is not accompanied by targeted support and alternative pathways.

6.6 Mechanisms for Successful Implementation

The literature suggests that effective implementation depends on several interconnected mechanisms operating simultaneously across system levels.

A central mechanism is shared accountability. Prevention succeeds where organisations view rising need, delayed discharge, and avoidable deterioration as collective system responsibilities rather than problems belonging to individual sectors. Pooled budgets and jointly owned outcomes encourage this shared responsibility.

Protected investment is equally important. Evidence consistently demonstrates that preventative funding must be insulated from short-term operational pressures if systems are to maintain upstream interventions during periods of crisis demand (Humphries et al., 2016).

Implementation also requires a workforce skilled in enablement and strengths-based practice. Scandinavian reablement models demonstrate that prevention depends on professionals adopting a “doing with” rather than “doing for” philosophy (Rostgaard, 2018). This requires cultural change alongside technical training.

Integrated analytics represent another critical mechanism. Systems must be capable of identifying risk trajectories, monitoring outcomes, and evaluating intervention effectiveness across organisational boundaries (Embuldeniya et al., 2021). Without integrated measurement infrastructure, prevention remains difficult to evidence and sustain.

Finally, community co-production emerges as a recurring success factor. Prevention is more effective when services are designed collaboratively with local communities rather than imposed through top-down models. Co-production helps ensure that preventative interventions remain culturally appropriate, locally accessible, and responsive to diverse patterns of need.

6.7 Implications for Northern Ireland

Northern Ireland enters this agenda with a significant structural advantage through its integrated health and social care system. Unlike England, Scotland, and Wales, where health and social care structures remain institutionally separated, Northern Ireland already possesses organisational integration capable of supporting preventative reform. However, international evidence suggests that structural integration alone does not guarantee preventative practice.

The evidence reviewed throughout this section points toward several implications for Northern Ireland. First, prevention requires explicit and protected investment mechanisms. Without ring-fenced funding, preventative services are likely to be displaced by acute demand pressures, particularly during periods of financial constraint.

Second, workforce development must be treated as a core component of prevention strategy rather than a parallel workforce issue. Investment in reablement skills,

technology enabled care, strengths-based practice, and multidisciplinary working is essential for implementation success.

Third, Northern Ireland requires stronger interoperability between health and social care data systems to support earlier identification of frailty, isolation, and escalating need. International models demonstrate that predictive and preventative systems depend heavily on integrated information infrastructure.

Fourth, governance arrangements should extend beyond health and social care alone. Evidence from Wales (Chesterfield et al., 2021) and Canada (Farhana et al., 2025) demonstrates the importance of formally incorporating housing, community organisations, and voluntary sector partners into preventative planning structures.

Finally, implementation must remain sensitive to Northern Ireland’s distinctive demographic and geographic context, including rurality, deprivation patterns, and community inequalities. Preventative approaches that succeed internationally will require adaptation rather than direct transplantation.

Ultimately, the central challenge for Northern Ireland is not whether prevention is conceptually desirable, but whether the system can sustain long-term preventative investment in the face of continuing operational pressures. International evidence consistently demonstrates that prevention succeeds when it becomes embedded within funding, accountability, workforce culture, and organisational priorities rather than remaining a policy aspiration operating at the margins of crisis-driven systems.

7. Recommendations for Northern Ireland

7.1 Overarching Strategic Recommendation

- **Recommendation 1: Adopt a Statutory Prevention Framework for Adult Social Care**

Northern Ireland should establish a statutory prevention framework for adult social care that embeds prevention as a core legal and operational duty across the health and social care (HSC) system. Prevention should no longer be treated as a discretionary aspiration or isolated programme but as a central organising principle

underpinning commissioning, assessment, workforce development, service delivery, and performance management.

The framework should provide:

- A clear statutory definition of prevention and early intervention
- Dedicated and protected prevention funding streams
- Shared accountability across HSC trusts, housing, and community sectors
- Standardised outcome and measurement frameworks
- A long-term implementation and evaluation strategy
- Formal duties relating to early identification, reablement, and wellbeing promotion

The international evidence reviewed throughout this report demonstrates that jurisdictions achieving the strongest preventative outcomes are those where prevention is embedded within legislation, funding mechanisms, and regulatory systems rather than dependent on discretionary local action. Denmark’s legislated reablement requirement, Wales’s statutory partnership structures, and England’s regulatory prevention metrics all illustrate the importance of formal system-level obligations.

The evidence also demonstrates that prevention fails where conceptual ambiguity persists. Godfrey (2001) and Verity et al. (2022) both highlight the persistent lack of definitional clarity surrounding prevention in adult social care. Without shared operational definitions, services struggle to commission, implement, or evaluate prevention consistently.

Equally important is the issue of financial sustainability. International evidence consistently demonstrates that short-term funding cycles undermine preventative reform because resources are repeatedly redirected toward immediate crisis demand (Marczak et al., 2019; Keemink et al., 2023). Prevention requires long-term investment horizons aligned with the timescales over which preventative outcomes emerge.

Finally, accountability mechanisms are essential. Needham and Hall (2023) demonstrate that prevention duties without measurable accountability often fail to translate into front-line practice. Prevention becomes operationally meaningful only when systems are required to demonstrate measurable progress against agreed outcomes.

Northern Ireland possesses a significant structural advantage through its integrated HSC system. Unlike the organisationally fragmented arrangements in England, Scotland, and Wales, Northern Ireland already has a unified system capable of supporting integrated preventative pathways. However, the international evidence is clear that structural integration alone does not guarantee preventative practice (Ploeg et al., 2010; Wojtak, 2026). Integration must be supported by explicit mandates, workforce investment, shared outcomes, and sustained political commitment.

7.2 Specific Recommendations

- **Recommendation 2: Establish Clear Operational Definitions of Prevention and Early Intervention**

Northern Ireland should consider adopting the working definitions proposed in Section 3 as the foundation for all prevention policy, commissioning, and evaluation activity.

These definitions should:

- Distinguish clearly between primary, secondary, and tertiary prevention
- Differentiate prevention from early intervention
- Define the relationship between universal, targeted, and reablement services
- Clarify what constitutes preventative activity within commissioning and funding arrangements
- Establish shared terminology across all five HSC trusts

The evidence consistently demonstrates that conceptual ambiguity remains one of the greatest barriers to implementation (Godfrey, 2001; Verity et al., 2022). Without definitional clarity, prevention risks becoming an umbrella term encompassing almost any service activity, limiting accountability and weakening strategic coherence.

Agreed definitions should therefore be embedded within statutory guidance, commissioning frameworks, workforce training standards, and performance metrics to ensure consistency across the system.

- **Recommendation 3: Establish Reablement as the Default Tertiary Prevention Pathway**

Northern Ireland should embed reablement as the default response for individuals experiencing functional decline before long-term care packages are approved.

This approach should include:

- Mandatory reablement assessment before long-term domiciliary care allocation
- Time-limited interventions, typically lasting six to twelve weeks
- Multidisciplinary delivery involving occupational therapists, physiotherapists, nurses, and social care staff
- Goal-oriented approaches focused on restoring independence
- Strengths-based practice centred on “doing with” rather than “doing for”
- Standardised outcome measurement focused on functional improvement and reduced dependency

The international evidence base for reablement is particularly strong. Scandinavian systems demonstrate that reablement is most effective when embedded as a legislated default rather than an optional service (Rostgaard, 2018). Evidence from Sweden’s Härnösand model showed that 93 per cent of participants reduced their need for home care support following intervention (Interreg Europe, 2025).

Reablement also offers significant system-level benefits. Research demonstrates improvements in functional independence, reductions in long-term care dependency, and greater cost-effectiveness compared with maintenance-based home care models (Welsh Government, 2021; Rostgaard, 2018).

- **Recommendation 4: Implement Systematic Risk Identification and Early Intervention Pathways**

Northern Ireland should implement systematic risk identification and early intervention pathways across primary care, community services, and adult social care.

This should include:

- Standardised frailty, falls, nutrition, and carer strain assessments
- Shared screening tools across health and social care settings
- Structured referral pathways linking assessment to intervention
- Integrated data collection and feedback systems
- Population-level risk stratification to identify high-risk individuals early
- Routine monitoring of functional trajectories over time

The Swedish Senior Alert model demonstrates how preventative assessment can be embedded into routine practice through structured feedback loops and standardised risk monitoring (Senior Alert, 2025). Similarly, Scotland’s Frailty Lead model illustrates the importance of integrating prevention within primary care pathways.

Evidence reviewed by Keemink et al. (2023) found that interventions linked to clearly defined pathways—particularly frailty and falls pathways—produce stronger outcomes than generic preventative approaches. This suggests that prevention is most effective when targeted, structured, and linked directly to actionable interventions.

- **Recommendation 5: Invest in Workforce Capability as a Core Prevention Enabler**

Northern Ireland should treat workforce development as a central pillar of prevention reform rather than a separate operational issue.

A prevention-oriented workforce strategy should include:

- Mandatory training in strengths-based and enablement-focused practice
- Expanded multidisciplinary team models
- Training in technology enabled care and digital prevention tools
- Workforce wellbeing and retention strategies
- Career progression pathways within community and preventative services
- Leadership development focused on preventative system transformation

The evidence consistently identifies workforce stability and capability as prerequisites for successful prevention. Prevention depends heavily on relational continuity, early identification of deterioration, and confidence in restorative approaches.

PA Consulting (2026) found that only 16 per cent of adult social care leaders believed their workforce fully understood the benefits of technology enabled care. Similarly, the ADASS Autumn Survey (2024) identified workforce investment as essential to future system sustainability.

International evidence from Canada and Scandinavia further demonstrates that preventative systems require stable, well-supported workforces capable of delivering relationship-based care over time.

- **Recommendation 6: Develop Integrated Data Infrastructure for Prevention**

Northern Ireland should invest in integrated data infrastructure capable of supporting predictive, preventative, and population-based approaches to care.

Key priorities should include:

- Full interoperability between health and social care systems
- Shared data standards across all HSC trusts
- Risk stratification tools for identifying rising need
- Real-time preventative dashboards and reporting systems
- Integrated outcome measurement frameworks
- Robust governance and information-sharing protocols
- Analytical capacity at both trust and regional levels

The international evidence demonstrates that effective prevention depends heavily on integrated information systems capable of identifying risk before crisis occurs (NHS England, 2025). Denmark and Sweden have both demonstrated the value of embedding prevention metrics within routine national data systems.

The ADASS Autumn Survey (2024) found that joined-up health and social care data was “transformative” in understanding patterns of need and targeting intervention effectively.

Northern Ireland’s integrated HSC structure provides an opportunity to develop system-wide preventative analytics more rapidly than more fragmented jurisdictions.

- **Recommendation 7: Strengthen Community and Voluntary Sector Partnerships**

Northern Ireland should position community and voluntary sector organisations as core partners within the prevention framework rather than supplementary providers.

This should involve:

- Stable multi-year funding arrangements for community partners
- Expanded social prescribing pathways
- Stronger links between primary care and local community infrastructure
- Asset-based community development approaches
- Co-production mechanisms involving service users and carers
- Rural and locality-sensitive prevention models

The evidence consistently demonstrates that prevention is most effective when rooted within communities and social networks rather than solely within formal services (Verity et al., 2022).

The mPower evaluation in Northern Ireland highlighted positive impacts on wellbeing and social connectedness where preventative approaches were closely linked to local voluntary and community infrastructure (Terje et al., 2022). Similarly, Wales and Canada both demonstrate the importance of formal partnership arrangements involving community organisations in preventative planning and delivery.

7.3 Phased Implementation Approach

International evidence demonstrates that prevention reform requires phased implementation over multiple years rather than rapid system-wide restructuring. Northern Ireland should therefore adopt a staged implementation strategy that balances ambition with operational feasibility. The use of implementation science will assist in ensuring full implementation across a complex system.

- **Phase One (0–12 Months): Foundation and System Preparation**

The initial phase should focus on establishing the structural and policy foundations necessary for implementation.

Key priorities should include:

- Establishing the statutory prevention framework
- Adopting formal operational definitions
- Creating governance and accountability arrangements
- Developing detailed implementation plans
- Establishing prevention funding mechanisms
- Initiating workforce consultation and capability assessments
- Beginning data-sharing and interoperability development
- Identifying pilot populations and geographical areas

This phase is essential because prevention cannot be implemented consistently without shared definitions, governance structures, and measurement systems.

- **Phase Two (12–24 Months): Piloting and Evaluation**

The second phase should focus on testing key preventative models within selected trusts or population groups.

This phase should include:

- Piloting reablement-first pathways
- Introducing standardised risk identification tools
- Testing integrated multidisciplinary models
- Expanding community partnership initiatives
- Implementing workforce training programmes
- Establishing baseline outcome measures
- Conducting rigorous process and economic evaluation

This phase is critical for determining how international models translate into the Northern Ireland context before wider system rollout.

- **Phase Three (24–48 Months): Scaling and System Integration/Implementation**

The third phase should focus on expanding successful approaches across the entire HSC system.

This should involve:

- Scaling successful prototypes across all trusts
- Embedding prevention within commissioning frameworks
- Integrating prevention metrics into performance management
- Expanding predictive analytics capability
- Implementing standardised prevention pathways system-wide
- Embedding prevention within workforce and professional standards

This phase represents the transition from isolated innovation to system-wide transformation.

- **Phase Four (48–60 Months): Consolidation and Continuous Improvement**

The final phase should focus on embedding prevention as a routine feature of HSC culture, governance, and practice.

This should include:

- Continuous quality improvement mechanisms
- Ongoing co-production with service users and carers
- Regular review and updating of evidence and guidance
- Longitudinal outcome monitoring
- Sustained workforce development programmes
- Embedding prevention into routine commissioning and financial planning

The international evidence demonstrates that prevention succeeds where it becomes culturally embedded within systems rather than remaining dependent on short-term reform programmes. This final phase is therefore essential to ensuring long-term sustainability and continuous improvement.

8. Conclusion

8.1 Summary of Key Findings

This review examined international evidence on prevention and early intervention in adult social care across England, Scotland, Wales, Scandinavia (Denmark, Norway, and Sweden), Australia, and Canada. Across these jurisdictions, a consistent conclusion emerges: prevention is most effective when it is embedded as a core organising principle of the system rather than treated as a discretionary or short-term initiative.

The international evidence demonstrates that prevention requires more than policy ambition alone. Jurisdictions that have made the greatest progress have combined

statutory duties, long-term investment, integrated governance, workforce development, and robust measurement frameworks. Denmark’s legislated reablement model, Sweden’s Senior Alert system, Wales’s Regional Partnership Boards, Scotland’s investment in technology enabled care, and Canada’s integrated care partnerships all demonstrate that prevention succeeds when supported by clear operational structures and sustained implementation mechanisms.

The review also found that definitional clarity is essential. Across the literature, inconsistent use of the terms prevention and early intervention continues to undermine implementation, commissioning, and evaluation (Godfrey, 2001; Verity et al., 2022). Establishing shared operational definitions is therefore a foundational requirement for Northern Ireland’s framework.

The strongest evidence base relates to reablement and targeted risk identification. International evidence consistently shows that reablement improves functional independence, delays or reduces long-term care needs, and supports ageing in place (Welsh Government, 2021; Rostgaard, 2018). Scandinavian models demonstrate the value of embedding reablement as the default response to functional decline rather than an optional service offer. Similarly, Sweden’s Senior Alert model and Scotland’s Frailty Lead approach illustrate the importance of systematic early identification pathways linked to clear interventions.

The review further demonstrates that integration is necessary but insufficient on its own. Northern Ireland’s integrated health and social care (HSC) system provides a significant structural advantage compared with more fragmented systems internationally. However, evidence from England, Wales, and Canada shows that structural integration does not automatically produce preventative practice. Prevention requires aligned incentives, shared accountability, dedicated funding, and strong local implementation capacity.

Workforce capacity emerged repeatedly as a critical enabler. International experience demonstrates that prevention depends upon a stable, skilled workforce capable of delivering relational, strengths-based, and multidisciplinary care.

Workforce instability, fragmented commissioning, and crisis-driven operating environments remain major barriers to preventative delivery.

Finally, the review found that jurisdictions making the strongest progress on prevention have invested heavily in measurement and evaluation. Denmark’s national indicator framework and Sweden’s quality registers demonstrate that prevention must be measurable, transparent, and embedded within routine system performance management.

8.2 Implications for Northern Ireland

The evidence suggests that Northern Ireland is well positioned to move toward a prevention-focused adult social care model, but success will depend on whether prevention is translated from strategic ambition into operational reality.

The key policy lesson from the international evidence is that prevention cannot sit at the margins of the system. It must be embedded within legislation, commissioning, workforce planning, regulation, and performance management. Jurisdictions that relied primarily on local discretion or short-term pilot funding achieved limited and inconsistent progress. Those that embedded prevention into statutory duties, funding models, and accountability structures achieved more sustained system change.

For Northern Ireland, this means that prevention should be treated as a whole-system reform agenda rather than a programme of isolated initiatives. Reablement should become the default pathway for people experiencing functional decline. Early identification and risk stratification should be embedded across primary care, community services, and social care. Workforce development should be recognised as a core prevention investment rather than a separate workforce issue. Data infrastructure and shared measurement systems should be established from the outset.

The international evidence also highlights the importance of adapting reform to local context. The most effective jurisdictions did not simply import external models; they adapted evidence-based approaches to fit local governance arrangements,

geography, demographics, and community capacity. This is particularly important in Northern Ireland, where rurality, community networks, and integrated HSC structures create both distinctive opportunities and implementation challenges.

8.3 Final Reflection

The international evidence is clear that prevention is achievable, but only when supported by sustained political commitment, long-term investment, and system-wide implementation. The challenge for Northern Ireland is no longer whether prevention should be pursued, but whether the necessary structural, financial, and cultural changes will be made to support it.

Northern Ireland has an opportunity to build upon its integrated HSC system and develop a prevention framework that is evidence-informed, measurable, and operationally credible. The experiences of England, Scotland, Wales, Scandinavia, Australia, and Canada provide valuable lessons on both what enables progress and what constrains it.

The central lesson from this review is that prevention is not a single intervention or service model. It is a different way of organising adult social care: shifting the focus from crisis response toward earlier support, independence, and long-term wellbeing. Achieving that shift will require prevention to move from policy aspiration to embedded system practice.

References

- ADASS. (2024). *The ADASS autumn survey: Balancing budgets, workforce stabilization, and long-term prevention*. Association of Directors of Adult Social Services.
- ADASS. (2025). *The DASS guide: Early intervention and prevention*. Association of Directors of Adult Social Services.
- Anell, A., Glenngård, A. H., & Merkur, S. (2012). Sweden: Health system review. *Health Systems in Transition*, 14(5), 1–159.

Australian Government Department of Health and Aged Care. (2025). *A new era for aged care in Australia*. Canberra: Australian Government Department of Health and Aged Care.

Backlund, A., Holmbeck, O., Kumlien, C., Axelsson, M., & Skog, M. (2018). A registry study of nursing assessments, interventions and evaluations according to nutrition for persons living in municipal residential care homes. *Nursing Open*, 5(3), pp. 341–350.

Bottery, S. (2024). *Social care 360*. The King's Fund.

Care Quality Commission. (2024). *State of care: Assessing local authority delivery of Care Act duties on independence and prevention*.

Chapman, A. (2020). Person-centred care in Northern Ireland. *Journal of Integrated Care*, 29(3), 242–253.

Chesterfield, A., Edwards, M., & Williams, L. (2021). Evaluative frameworks for integrated governance: Assessing the impact of Welsh Regional Partnership Boards. *Journal of Integrated Care*, 29(3), 245–258.

Dayan, M., Edwards, N., & McKenna, H. (2019). *Change or collapse: Lessons on health and social care reform from Northern Ireland*. Nuffield Trust.

Department of Health. (2025). *Health survey Northern Ireland: First results 2024/25*. Belfast: Department of Health.

Department of Health. (2026a). *10-year strategic plan for adult social care reform*. Belfast: Department of Health.

Department of Health. (2026b). *Adult social care reform: Three-year delivery plan 2025–2028*. Belfast: Department of Health.

Department of Health. (2026c). *Publication of the quarterly Northern Ireland outpatient, inpatient and day case, and diagnostic waiting times statistics - position on 31 December 2025*. Belfast: Department of Health.

Department of Health. (2026d). *Neighbourhood model of health and wellbeing: Shifting left*. Belfast: Department of Health.

Department of Health and Social Care. (2026). *Better Care Fund 2026–27: Policy framework and planning requirements*. London: DHSC.

Dupuis-Blanchard, S. (2025). A science-based solution to help older Canadians age in place: Scaling up Nursing Home Without Walls. Canadian Institutes of Health Research.

Dupuis-Blanchard, S., Gould, O. N., & Read, J. (2018). Nursing Homes Without Walls for aging in place. *Canadian Journal on Aging*, 37(4), 442–449.

Edvinsson, J., Rahm, M., Trinks, A., & Höglund, P. J. (2015). Senior Alert: A quality registry to support a standardized, structured, and systematic preventive care process for older adults. *Journal of Gerontological Nursing*, 41(4), 11–16.

Embuldeniya, G., Gutberg, J., Sibbald, S. S., & Wodchis, W. P. (2021). The beginnings of health system transformation: How Ontario Health Teams are implementing change in the context of uncertainty. *Health Policy*, 125(12), 1543–1549.

Fagerström, C., Elmståhl, S., & Wrangler, L. S. (2017). Analyzing preventive care using Senior Alert. *International Journal of Integrated Care*, 17(5), A127.

Farhana, N., et al. (2025). Operationalizing accountability for integrated care: A qualitative study of an Ontario Health Team. *Healthcare Management Forum*, 39(3).

Fang, Y., Chiu, C. J., & Chang, M. C. (2019). Digital health inequality among older adults. *Frontiers in Public Health*, 7, 268–279.

Future of Prevention (2025). *Delivery model for targeted prevention*. <https://www.futureofprevention.com/delivery-model>

Godfrey, M. (2001). Prevention: A shared conceptual framework. *Health & Social Care in the Community*, 9(3), 138–147.

Government of Ontario. (2026). WSIB coverage expansion for frontline care workers. Toronto: Queen’s Printer for Ontario.

Hendriksen, C., & Vass, M. (2021). Preventive home visits to older people in Denmark: A 25-year history of policy, practice, and academic evaluation. *European Journal of Ageing*, 18(3), 311–320.

Hoddinott, S. (2025). *Adult social care across England: Performance Tracker Local*. Institute for Government.

Humphries, R., Galea, A., & Hall, P. (2016). *Securing good health for the whole population: Multi-year budgeting and preventative spend*. The King’s Fund.

Interreg Europe. (2025). Härnösand Municipality: Prevention and early intervention in social care. Brussels: Interreg Europe.

Kallings, L. V. (2011). Physical activity on prescription (FaR) in Swedish primary health care (Report R2011:08). Swedish National Institute of Public Health.

Kay, K., & Webster, S. (2026). Consensus statement: Care for the older adult with complex health conditions—Reframing ‘frailty’ in an Ontario health team context. Provincial Geriatrics Leadership Ontario & Centre for Studies in Aging and Health.

Keemink, J. R., Glass, D., Dargan, A. K., Sharp, R. J., & Forder, J. E. (2023). The role of adult social care in the prevention of intensive health and care needs: A scoping review. *Journal of Long-Term Care*, 350–378.

Kjelvik, J., & Söderberg, M. (2020). Reablement in Scandinavia: A comparative analysis of policy and practice. *Nordic Journal of Social Research*, 11(1), 45–62.

Kvist, J. (2018). The Danish long-term care system. European Social Policy Network & European Commission.

Lette, M., Baan, C. A., van den Berg, M., & de Bruin, S. R. (2015). Initiatives on early detection and intervention to proactively identify health and social problems in older people: experiences from the Netherlands. *BMC Geriatrics*, 15(143), 1–13.

Marczak, J., Wistow, G., & Fernandez, J.-L. (2019). Evaluating social care prevention in England: Challenges and opportunities. *Journal of Long-Term Care*, 206–217.

Marchildon, G. P., Allin, S., & Merkur, S. (2021). *Health Systems in Transition: Canada*, 3rd edn. University of Toronto Press.

McDaid, D., Park, A., Bond, N., & O'Neill, S. (2026). *The economic case for a mental Health Regional crisis intervention service in Northern Ireland*. London: Care Policy and Evaluation Centre, London School of Economics and Political Science; Belfast: Office of the Mental Health Champion for Northern Ireland.

McMullen, S., O'Hare, U., & Ellison, C. (2026). *Disability and poverty in Northern Ireland*. York: Joseph Rowntree Foundation. York: Joseph Rowntree Foundation.

McNally, S. (2020). Exercise: The miracle cure for surgeons to fix the NHS and social care. *The Bulletin of the Royal College of Surgeons of England*, 102(1), 28–33.

NDIS Review. (2023). *Working together to deliver the NDIS: Independent Review into the National Disability Insurance Scheme: Final report*. Commonwealth of Australia, Department of the Prime Minister and Cabinet.

Needham, C., & Hall, P. (2023). Dealing with drift: Comparing social care reform in the four nations of the UK. *Social Policy & Administration*, 57(3), 287–303.

Needham, C., & Hall, P. (2023). Prevention as a statutory duty. *Journal of Social Policy*, 52(2), 341–359.

NHS England. (2025). *Federated Data Platform: Implementation update*. London: NHS England.

Nilsen, P., Festin, K., & Bendtsen, P. (2011). Health promotion in Swedish primary care. *BMC Family Practice*, 12(1), 114–122.

NISRA. (2026). *2024-based population projections for Northern Ireland*. Belfast: Northern Ireland Statistics and Research Agency.

Olejaz, M., Juul Nielsen, A., Rudkjøbing, A., Okkels Birk, H., Krasnik, A. & Hernández-Quevedo, C. (2012). Denmark: Health system review. *Health Systems in Transition*, 14(2), 1–192.

O'Neill, S. (2026). *Mental health in Northern Ireland: Current services and strategic priorities*. Belfast: Office of the Mental Health Champion for Northern Ireland.

Onerup, A., et al. (2019). Physical activity on prescription (Swedish model). *British Journal of Sports Medicine*, 53(6), 383–388.

Ontario Caregiver Organization (2024). *Spotlight report: The realities of caregiver burnout and systemic strain in the health care system.*

Ontario Health Team of Northumberland. (2026). About OHT-N: Integrated health services. Cobourg: OHT-N.

PA Consulting. (2026). TEC outlook 2026: Sustaining progress, scaling impact. London: PA Consulting.

Ploeg, J., Brazil, K., Hutchison, B., Kaczorowski, J., Dalby, D. M., Goldsmith, C. H., & Furlong, W. (2010). Effect of preventive primary care outreach. *British Medical Journal*, 340, c1480.

Rostgaard, T. (2018). Reablement as a preventative strategy in Nordic municipal care. *European Journal of Social Work*, 21(6), 855–867.

Rostgaard, T. (2024). Standardising reablement in Denmark. *International Journal of Social Welfare*, 33(2), 412–425.

Rostgaard, T., & Graff, L. (2025). Workforce outcomes in reablement-focused social care systems. *Journal of Long-Term Care*, 8(2), 112–128.

Rostgaard, T., Jacobsen, F., & Graff, L. (2022). Prevention in adult social care: A Nordic perspective. Copenhagen: Danish Centre for Social Research.

Scottish Government. (2025). Health and social care service renewal framework. Edinburgh: Scottish Government.

Scottish Government. (2026). Frailty enhanced service: GP practice guidance. Edinburgh: Scottish Government.

Senior Alert. (2025). Senior alert – more than just a quality register. Stockholm: Senior Alert.

Skills for Care. (2019). *Prevention in social care: Where are we now?* Leeds, UK: Skills for Care.

Skills for Care. (2024). *The state of the adult social care sector and workforce in England.*

Social Care Institute for Excellence (SCIE). (2021). *Prevention in social care*. London: Social Care Institute for Excellence.

Spiers, G., et al. (2019). Impact of social care supply on healthcare utilisation. *Age and Ageing*, 48(1), 57–66.

Swedish National Board of Health and Welfare. (2022). Preventive home visits for older people: National guidelines. Stockholm: Socialstyrelsen.

Terje, A., Munoz, S., & Hall, J. (2022). Evaluation – mPower. University of the Highlands & Islands.

Tew J., Duggal, S., Carr, S., Ercolani, M., Glasby, J., Kinghorn, P., Miller, R., Newbigging, K., et al. (2019). Implementing the Care Act 2014: building social resources to prevent, reduce or delay needs for care and support in adult social care in England. Birmingham: University of Birmingham.

Tew, J., Duggal, S., & Carr, S. (2023). How has the idea of prevention been conceptualised and progressed in adult social care in England? *Journal of Social Policy*, 54(2), 429–447.

Thiery, H., Cook, J., Burchell, J., Wilberforce, M., Twiddy, M., Nikolova, S., Martin, A., & Hulme, C. (2023). Transforming adult social care systems? A systematic review of the costs and outcomes of local area coordination in England and Wales. *Social Sciences & Humanities Open*, 8(1), 100714.

Thomas, J., & Harden, A. (2008). Thematic synthesis methods. *BMC Medical Research Methodology*, 8(1), 45.

Tricco, A. C., Langlois, E. V., & Straus, S. E. (2017). Rapid reviews guide. World Health Organization.

Varker, T., et al. (2015). Rapid evidence assessment methodology. *Journal of Evaluation in Clinical Practice*, 21(6), 1199–1204.

Vass, M., Avlund, K., Lauridsen, J., & Hendriksen, C. (2007). Preventive home visits indicators. *Health & Social Care in the Community*, 15(5), 410–422.

Verity, F., Richards, J., Read, S., & Wallace, S. (2022). Prevention narrative integrative review. *Health & Social Care in the Community*, 30(1), 50–62.

VON Canada. (2025). SMILE programme. Ottawa: VON Canada.

Welsh Government. (2014). *Social Services and Well-being (Wales) Act 2014*. Cardiff: Welsh Government.

Welsh Government. (2021). Rapid review of evidence on reablement. Cardiff: Welsh Government.

Welsh Government. (2024). Regional Partnership Boards: Statutory guidance. Cardiff: Welsh Government.

Welsh Government. (2025). *Intermediate Care Fund: Annual report 2024–25*. Cardiff: Welsh Government.

Welsh Government. (2026). *Adult social care priorities 2026–27*. Cardiff: Welsh Government.

Wenzel, L., Morris, L., Chikwira, L., & Nwasike, C. J. (2026). What makes care outstanding? The King’s Fund report. The King’s Fund.

Wong, W. C.-W., Lin, V., Fang, X., Kidd, M., & Lancet Commission on Transforming Primary Health Care in the Post-COVID-19 Era. (2025). *The Lancet Commission on transforming primary health care in the post-COVID-19 era*. The Lancet, 405(10478), 527–528.

Wojtak, A. (2026). Advancing integrated care at scale: Lessons from Ontario Health Teams. *International Journal of Integrated Care*, 26(1), 1–12.