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FOR WHAT COMES NEXT

Why digital adult social care transformation is central to the future of the NHS

A white paper from the techUK Social Care Working Group

June 2026

About techUK

techUK is the trade association that brings together people, companies and organisations to realise the positive outcomes of what digital technology can achieve. With over 1,150 members across the UK, techUK creates a network for innovation and collaboration across business, government and stakeholders to provide a better future for people, society, the economy and the planet.

By providing expertise and insight, techUK supports our members, helps the government understand the impact of their policies on business, and draws together the industry and public sector to agree the right approach to how digital technology policy is developed and implemented.

techUK's Health and Social Care Programme represents around 400 companies across the UK health technology sector, and is one of the most active programmes in the organisation. It convenes suppliers, providers, commissioners and policymakers through more than 70 events a year, including workshops, roundtables, conferences and consultation responses, alongside thought leadership and direct policy advocacy.

The programme maintains direct working relationships with the Department of Health and Social Care, Devolved Nations, NHS England, the MHRA, NICE, Health Innovation Networks, the Office for Life Sciences, and ICSs and ICBs across the country, giving members structured access to the people shaping national strategy, regulation and delivery. A particular focus is convening structured, unbiased pre-market engagement with the NHS and wider public sector, giving access to the breadth of supplier insight before procurement specifications are finalised, and giving industry a meaningful voice in the design of national programmes.

The techUK Social Care Working Group (SCWG) aims to give adult social care a stronger and more consistent voice within the digital transformation agenda. At its heart are the techUK members most directly involved in delivering care through technology, including housing, professional services, telecoms, telecare and software. Working closely with policy, commissioning and provider organisations across the sector, the group identifies practical, deliverable ways that digital technology can support reform in adult social care, improve integration with the NHS, and enable prevention-led, community-based models of care.

techUK is committed to working in close partnership with DHSC, NHS England and other government departments, regulators and partners to help deliver the recommendations in this paper.

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Foreword

Sir David Pearson CBE
Chair of TEC Quality

I am very pleased to welcome this White Paper by techUK.

We are at a time of significant change in both the world of social care and technology. The report provides a detailed analysis of the opportunities that technology can bring. It also highlights some good examples of change in practice with the benefits it brings to the people who need social care in this country and those who are striving to improve services through innovation.

I hope that it will prompt debate and stimulate action to ensure that the digital transformation of Adult Social Care is given the impetus and support it needs. Digital technologies can help to ensure that people who need social care of all ages are enabled to live their best lives, that the workforce have the benefit of technology to aid them in their work of being as effective as they can be in supporting people in our communities.

There is now a groundswell of evidence that digital solutions can significantly benefit those who need social care, health and housing. The future contribution of technologies, including artificial intelligence is under the spotlight.

We know that digital devices and systems are a way of enabling and joining up services, providing a platform for preventative, proactive and personalised care and support. It can also ensure that we are anticipating need and risk and supporting the workforce to address local need.

This report argues for a concerted approach to make sure all the right levers are pulled and makes specific recommendations for all those with a responsibility. It is only through concerted action by government, national bodies, the NHS, those representing local government and social care, housing and health providers, along with the tech industry, that we will be able to implement and scale the innovative solutions that are within our grasp.

As Chair of TEC Quality, the organisation that runs TSA's Quality Standards Framework (QSF), making progress safely and effectively is a big priority for me. We'll only be able to take advantage of the opportunities if the public trusts that the right technology is being used in a way that supports the public and is safe. We need to ensure that digital technologies help provide more effective social care and that we can truly integrate safely and effectively with the right standards and approaches, alongside a workforce that is properly trained and equipped.

I look forward to working with techUK and many other partners to realise our collective ambition of improving services - and lives - for people who draw on social care.

Executive overview

Adult social care transformation is critical to delivering the NHS 10-Year Plan. The Plan's three strategic shifts (hospital to community, analogue to digital, sickness to prevention) all depend on what happens in people's homes and neighbourhoods, where adult social care already operates at scale.

The technology to support that shift already exists. Predictive monitoring, interoperable records, AI-enabled decision support, digital telecare and data-driven prevention are mature, deployed capabilities. The opportunity is to build the coordination layer around the technology, designed on open standards and vendor-neutral principles, so the sector retains the freedom to evolve over time. That means aligning commissioning approaches, consolidating data standards, joining up assurance, strengthening interoperability, and developing shared accountability across health, care, government and industry.

This is a particularly timely moment. **The 10-Year Plan**, the **Casey Commission, local government reorganisation**, the **analogue-to-digital (A2D) telecare transition**, and national interoperability programmes are converging, and risk progressing independently rather than together.

The central proposition is that there is a significant opportunity to improve prevention, reduce avoidable NHS demand, strengthen neighbourhood care, and increase productivity through better coordination of capabilities already in the system, with technology as a key driver, and without waiting for longer-term reform and funding settlements.

Transformation on this scale takes time, and the full benefits build over years rather than overnight. But acting now on the coordination is what allows those gains to compound. Much of the work can be funded by redirecting existing money through NHS prevention funding, the Better Care Fund, and Section 75 pooled budgets, rather than waiting for new settlements.

Industry has a substantial part to play in turning that opportunity into delivery. This paper sets out the principles on which industry stands ready to engage, the practical contributions the supplier ecosystem can make, and also concludes with recommendations for national government, local and strategic authorities, ICSs, and ICBs.

Decisions Ministers Can Take Now

- Mandate minimum adult social care interoperability standards built on open APIs and open standards, that are co-developed with industry.
- Direct the CQC and NHS England to set out how the digital signals that care technologies

produce, such as alert logs, decision trails and escalation histories, can be used as evidence of care delivered.

- Make existing prevention funding explicitly available for service redesign as well as technology procurement.
- Require all upcoming neighbourhood health programmes to structurally integrate housing and adult social care data flows.
- Enable and expect pooled NHS and local authority prevention budgets, using existing Section 75 flexibilities, with mechanisms to recognise where savings land across the system.
- Move towards a single, reusable and proportionate assurance regime recognised across CQC, DTAC, DSPT and MHRA, to reduce duplication for suppliers, particularly SMEs.
- Involve care providers early in the design of interoperability and neighbourhood health programmes, and test that digital requirements deliver a real operational benefit for providers, not only a system-level benefit elsewhere.
- Support pre-procurement engagement that gives commissioners access to a wide range of suppliers, including SMEs, and support shared sandbox environments for testing and scaling new tools.

Introduction: Why digital adult social care transformation is central to the future of the NHS

The three shifts in the 10-Year Plan happen in homes, neighbourhoods and community settings as much as in hospitals.[1] Adult social care is the system that already operates at scale in those places. With local authority spending reaching £34.5 billion in 2024/25 and supporting 889,000 individuals through publicly funded long-term care[2], alongside its workforce, provider market, and commissioning structures, it functions as a system in its own right, and one whose role in delivering the Plan must be understood on those terms.

Baroness Casey's Independent Commission will address the structural questions, including funding, with reports due in 2026 and 2028.[3] This paper does not attempt to pre-empt her work. Rather, it argues that a parallel set of changes (in coordination, governance, commissioning, assurance and workforce capability) can be acted on now, with the evidence and technology already available.

The supplier market has built the tools that the 10-Year Plan depends on, and DHSC reported in December 2025 that material administrative time has been released across the sector as a result.[4] The next step is building the coordination layer around the technology, and several components need to come together to make that possible.

Data standards need to develop more consistently across providers so that systems can connect and data can move. Commissioning needs to specify outcomes rather than tools and hours of care, something techUK has consistently identified as a constraint on adoption.[5] Assurance frameworks need greater alignment so that suppliers and providers are not navigating overlapping regimes. Co-production with lived experience is increasingly recognised as essential and needs to be evidenced more consistently in practice. And workforce digital capability needs to develop more quickly across the sector.[6] Building that coordination layer is a shared task, and one in which industry has both an interest and a contribution to make.

Adult social care is often misunderstood as a service only for older people. In reality, it supports people throughout adult life. That includes working-age adults with learning, physical and sensory disabilities, long-term conditions and mental health needs; people experiencing homelessness, addiction or multiple disadvantages; and older adults living with frailty and dementia.

It also supports people moving between services as their needs change, including the critical transition from children's to adult services. Long-term support spending is split almost evenly between working-age adults and older people,[2] and the same person will often move between different parts of the system over time. What matters is designing for those transitions, and for the data sharing that makes them work.

The argument that follows is in three parts. The first sets out why adult social care sits at the centre of NHS reform. The second sets out what digitally enabled, place-based delivery looks like in practice, and the role industry can play in making it real. The third sets out what national government, local and strategic authorities, ICSs, ICBs and industry can each take forward.

Chapter 1: The strategic case for digitally enabled adult social care

1.1 Social Care as a System Enabler

The 10-Year Plan's three shifts describe activities delivered outside acute settings, by local authorities, care providers, housing organisations, primary care networks and the voluntary sector.[1] Adult social care sits at the centre.

Much of what shows up as pressure on NHS beds from delayed discharge begins upstream, in the way social care flows. Many avoidable emergency admissions reflect gaps in community support that only become visible once someone reaches A&E. For working-age adults with learning disabilities, physical disabilities or serious mental illness, social care is the principal organising service in their lives, and it shapes whether and how they engage with primary and secondary care.

NHS Confederation analysis found that ICSs investing more in community care saw 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, with a £131 return for every £100 spent.[7] Those reductions are produced by functioning community services, not by additional acute capacity. The digital

infrastructure underpinning those services at scale, records, telecare, predictive monitoring, rota optimisation, is largely built and supported by industry.

The 10-Year Plan's "Neighbourhood Health Service" framing makes this explicit.[1] Neighbourhood health works best when adult social care is treated as an equal partner in its design. Where it is positioned as a downstream pressure or a budget line competing with the NHS, neighbourhood ambitions are harder to realise at delivery. The Better Care Fund (£9 billion in 2025/26) provides an important bridge between two structurally separate settlements, and there is scope to develop it further as a unifying mechanism.[8] The investment case for a digitally enabled adult social care system is modest against NHS budgets and significant against the sector's own resources; what it buys, avoided admissions, sustained independence, reduced long-term care costs, is substantial and primarily realised by the NHS.

Importantly, for that investment to land, it must reach the providers actually delivering the care. If digitally enabled prevention is designed around NHS benefits while treating the provider market as a passive recipient, the model will not stick.

Care providers, and independent-sector providers in particular, are not simply delivery settings. They are the operational adopters of digital tools and the customers who ultimately fund supplier products. Much of the integration and interoperability that neighbourhood health depends on will not be funded directly by the NHS; in practice, it relies on suppliers prioritising development within crowded roadmaps, and suppliers prioritise the work that strengthens their offer to the customers who buy from them. For many of them, that customer base is care providers rather than the NHS or local authorities.

The same logic determines where digital integration actually takes hold. Where the main benefits accrue to the NHS, an ICB or a local authority, while the costs, workflow burden and implementation effort fall on providers and their suppliers, adoption is slower, and providers may understandably be cautious about integration that adds work, duplicates existing recording, or introduces new reporting expectations without supporting their own service delivery. The strongest foundation for adoption is a clear benefit to providers themselves: reduced administrative burden, safer handovers, better access to relevant clinical information, stronger quality and compliance, improved workforce efficiency, and less duplication. Where providers can see the benefit, suppliers have a far stronger basis for prioritising the development work that the wider shift relies on.

This logic does not stop at the level of individual deployments. National programmes set the procurement specifications, standards and integration patterns that providers and suppliers then must deliver against, and where those programmes are designed without industry at the table, specifications can be harder to meet, and integrations end up retrofitted rather than designed in. Unbiased pre-market engagement is a well-tested way to address this, giving commissioners access to the full breadth of supplier insight without favouring any individual provider. Provider and supplier engagement is a delivery dependency, not a matter of stakeholder management, and technology only scales where incentives align across the whole chain: the NHS, local authorities, care providers, suppliers, staff and the people drawing on care.

1.2 The Prevention and Economic Case

If the 10-Year Plan's commitment to prevention is to mean anything in delivery, adult social care must be central. Prevention as a clinical concept has focused on where the NHS interacts with people: vaccinations, screening, GP-led management of long-term conditions. These describe only a fraction of where prevention happens.

Most preventable escalations occur in domestic and community settings. A fall at home that goes undetected. A carer reaching their limit. A young adult arriving in adult mental health services in crisis, rather than primary care. In each case, the people who could have prevented the crisis were already there, and increasingly, so was the technology around them.

Social care is often the earliest point at which rising risk can be detected. A care worker visiting several times a week notices subtle changes; telecare alerts, ambient sensors and predictive analytics surface the same signals continuously and often earlier. This is as true for mental as for physical health: changes in routine, sleep, mood or engagement are often visible in the home long before a person reaches crisis or presents to clinical services. Together, workforce and technology can identify warning signs weeks or months before clinical presentation.

More than 80% of adult social care providers in England now operate digital social care records.[4] Around 2 million people across the UK rely on telecare services, with most being transitioned to digital platforms by January 2027.[9] Ambient AI, acoustic monitoring, predictive sensing and structured digital assessments are already being deployed across a growing number of settings, and are making a real difference to the people they support and the teams around them. These tools are the product of sustained investment by the supplier market, and they represent only a fraction of what the technology will be capable of within the lifetime of the 10-Year Plan. The capability is there; what is missing is the scale of adoption. The work ahead is less about inventing what comes next and more about creating the conditions in which what already works can reach the people who need it most.

The cost of late intervention is substantial and spread unevenly across the NHS, local authorities, housing providers and unpaid carers. Prevention savings are distributed across the same stakeholders, and the current funding architecture makes aggregating them across budget lines challenging, so the business case can look weaker on any single line than at system level. Falls alone cost the NHS in England an estimated £2.3 billion every year.[10] Once continuous formal support is needed, gross weekly fees average around £1,019 for older adults and £1,823 for working-age adults with complex needs.[2]

Prevention is not only about avoided cost; it is also an economic growth argument. Health and financial wellbeing are linked: good physical and mental health keeps people in work and independent, and reduces the number of working-age adults and unpaid carers pulled out of the labour market by ill health or caring. Poor health does the reverse, depressing participation, productivity and household resilience while feeding demand back into the system.[11]

Investment in digitally enabled prevention therefore protects both the public purse and the wider economy, an argument that speaks directly to the Treasury as well as to commissioners.

A great deal of evidence on what works already exists; the gap is in how it is collated and communicated, and in whether commissioners can see the scale of savings that good deployment makes possible. Two practical questions follow. The first is what evidence buyers actually find useful, and how to present it in a form that matches commissioning decisions. The second is what happens to the savings when they do materialise: where prevention savings are absorbed into filling immediate gaps rather than reinvested strategically, the invest-to-save case weakens. Both need addressing if prevention investment is to compound rather than dissipate.

Joint, outcome-based commissioning is the mechanism for addressing both. It sharpens the evidence question, because it specifies the outcomes a commissioner is buying and therefore the evidence they need; and, when paired with pooled budgets, it allows prevention savings to be reinvested across the system rather than absorbed into the immediate pressures. Section 75 pooled budget powers, the Better Care Fund's prevention element and Treasury invest-to-save rules already permit it.[8] The instruments are largely in place; the next step is supporting their consistent use across organisational boundaries, and developing the commissioning capability to do so confidently. Strengthening that capability will not require additional investment, just effort.

Case study

Lilli, Kyndi and Medway Council

The challenge

Medway Council's adult social care service faces significant demand pressures, with requests for care rising month on month and the complexity of need also increasing. The number of residents with dementia in Medway is estimated to rise by 38% by 2040. Against that backdrop, the council also needed to deliver millions of pounds of savings and cost avoidance within its adult social care budget. The challenge was how to maintain high-quality care while managing costs and resource pressures, and how to evidence where high-cost packages such as residential care referrals were unnecessary or overly restrictive. The aim was not to replace human care with technology, but to use technology to support the right level of care.

What we did

Working with Kyndi, the council-owned assistive technology company, the adult social care team implemented Lilli, smart home monitoring technology that uses discreet sensors and AI to understand how well someone is managing at home. By monitoring everyday behaviours including eating, drinking, mobility, sleep, hygiene and time outside, the insights support informed decisions about how independent someone is and the level of care they need, and flag when circumstances change so that interventions can be proactive rather than reactive.

Lilli was initially rolled out on the front door pathway to support initial care assessments and build an evidence base before being extended into learning disabilities and reablement, where cases are more complex. The main driver of scale has been a weekly best practice panel. Teams use it to discuss cases, focusing on packages above £400 per week, and review where the technology could support service users, for example, generating evidence for a move to residential care or for a reduction or increase in care visits. Teams now return to the panel regularly with positive results, embedding the service and shifting the culture.

The outcome

In the first year, Medway recorded over £1.5M in savings and cost avoidance, with tens of thousands of pounds in savings demonstrable within weeks of adoption. Care packages have been right-sized, and reliance on residential care has been reduced.

The qualitative outcomes are at least as significant. In some cases, the technology has evidenced that a waking-nights service was not needed, enabling better sleep for the person concerned. In others, it has supported older people to live in their own homes, with their pets and in their communities, for an extra six months, keeping community connection intact. Lilli has helped carers identify health decline early, for example flagging increased bathroom activity that indicated a UTI before it became a crisis admission. It has also given families reassurance and reduced their mental load, and given practitioners data to back up difficult conversations with the people they support.

As Jackie Brown, Assistant Director of Adult Social Services at Medway, put it: “Lilli is assisting us in transforming how care is delivered in Medway. It is driving a culture shift across the service, through which we are now led by data and insights to support us in making care package decisions.”

1.3 A Once-in-a-Generation Moment

Four forces are converging simultaneously. The question is whether they reinforce one another or pass each other by.

The Casey Commission has rightly reframed adult social care as a national priority,[3] and the operational pressures the sector faces mean that workforce, assurance, and delivery models can usefully develop in parallel with the Commission's work.

Local Government Reorganisation is rebuilding the institutional structures through which most adult social care is commissioned.[12] Done well, it allows digital, data and outcome-based commissioning to be embedded in the design of new authorities from the start, and gives industry an opportunity to engage on what good commissioning specifications look like before they harden into procurement templates.

The analogue to digital switchover is transforming the UK's telecare sector, with around 2 million people relying on telecare services to live safely and independently at home.[9] As analogue phone networks are withdrawn by January 2027, telecare systems must move from copper-based analogue technology to digital, IP-based solutions. Unlike analogue systems, which mainly support voice communication and alarm calls, digital solutions can collect and transmit richer data about a citizen's home, movement, and wellbeing. This creates opportunities for more proactive and preventative care, and the housing sector's experience working with this richer environmental data offers a useful precedent for how the same approach can support health and care outcomes.

National interoperability programmes (the **Digitising Social Care Records Programme**[4] and the **Single Patient Record** commitment[1]) are putting neighbourhood-level data architecture within reach. The data standards and integration patterns at the heart of these programmes are most likely to succeed where industry is engaged early in their design, so that what is mandated is what suppliers can credibly deliver. There is encouraging momentum in this direction. techUK has been working closely with the NHS England Single Patient Record team through 2026, **convening supplier roundtables and events** that have brought more than 100 industry leaders into structured dialogue on the programme's strategic vision and technical architecture. Extending this kind of open, pre-procurement engagement across other national programmes is one of the most practical ways to make the next phase of interoperability work in practice.

Each force alone is significant. None is owned by any single department or regulator, and they need to be drawn together at delivery level. Industry has a clear role: engaging visibly and collectively on the standards and ways of working that allow the four forces to reinforce one another and surfacing the practical obstacles that become apparent only at deployment.

Chapter 2: The Enablers of Digital Adult Social Care Transformation

2.1 Health, Housing and Social Care Working Together

The 10-Year Plan's neighbourhood ambition depends on practical coordination between health, social care, housing and community services, and on the digital infrastructure that allows practitioners to see, understand and respond.[1]

Housing matters as much as health and social care, and bringing it more fully into integration conversations is a major opportunity. Adaptations, fall hazards, heating, hoarding and tenancy stability shape care need as materially as any clinical factor. Housing providers hold data, infrastructure and relationships that the rest of the system can benefit from connecting to more directly. They are also absorbing significant regulatory and operational changes, including the Building Safety Act 2022 and Awaab's Law on damp and mould, which makes the pace and shape of integration something that needs to be designed with them rather than imposed on them. Where multiple housing providers operate in a single neighbourhood, common standards (for things like referral pathways, data sharing and reporting) make a tangible difference to frontline staff working across them, and the integration patterns already connecting digital care records to NHS systems offer a route that could be extended to housing systems.

Case study

Aico - HomeLINK technology with Selwood Housing

The challenge

Selwood Housing manages over 7,000 homes. We have been working with them since 2023 on a shift away from reactive maintenance toward predictive, data-driven decision-making across their portfolio. The introduction of Awaab's Law has significantly increased the need for timely investigation and resolution of hazards such as damp and mould, and the wider question has been how connected technology can support compliance while also giving residents themselves the tools to understand and influence the conditions in their homes.

What we did

We deployed Aico's HomeLINK technology, a system of Environmental Sensors, Gateways and cloud-based analytics that provide continuous visibility into indoor environmental conditions. The sensors monitor temperature, humidity and CO, transmitting data in real time to a central platform. What began as a pilot has scaled to more than 250 actively monitored properties, supported by over 2,000 connected IoT devices including environmental sensors, fire alarms and carbon monoxide alarms, integrated into a unified system via HomeLINK Gateways.

The system feeds analytics dashboards used by housing teams, enabling automated reporting, trend analysis and risk flagging, reducing reliance on manual inspections while increasing the accuracy

and frequency of monitoring. Rising humidity can be identified before visible mould appears, allowing intervention at a much earlier stage. After repair work, sensors continue to monitor conditions to confirm whether the intervention has been successful or further action is required: a closed-loop feedback system essential for meeting regulatory standards while ensuring long-term effectiveness.

The HomeLINK Resident App extends the system to tenants, translating sensor data into clear visual indicators and notifications. Healthy Home Indicators show whether conditions are within healthy ranges. Tailored Recommendations advise on ventilation or heating. Damp and Mould Alerts give proactive notifications with practical guidance. Device Maintenance Reminders prompt testing of fire and CO alarms. Trusted Access allows residents to securely share app access with family or carers. When a resident receives a notification, the same data is visible to Selwood's Damp and Mould Team, enabling a coordinated response.

The outcome

The deployment has shifted Selwood's compliance posture and operational model. Surveyors now rely on data insights to prioritise cases, and automated reports highlight properties at higher risk. Weekly data outputs provide actionable intelligence, enabling faster response times and more efficient resource allocation. The resident app has driven behaviour change at the household level: a notification about rising humidity may prompt a resident to open a window or improve ventilation, and over time these small actions contribute to improved indoor air quality and reduced incidence of damp and mould. Shared visibility between residents and housing teams reduces communication gaps and builds trust, with teams able to prioritise interventions based on data-driven risk assessments rather than reactive callouts. The model is scalable, with plans to install additional sensors in further properties as adoption continues.

Most of the data needed to coordinate care across the system is already being captured; the constraint is that it is rarely connected, interpretable in real time, or structured so it can be acted on at the point of decision. Some of that is a technical legacy: social care's systems grew up in a market where differentiation often meant bespoke data structures, and the conventions of that era did not make data easy to move between products. Those conventions are now changing. Open standards have matured, portability is an increasingly clear expectation, and interoperability is understood as a condition of growth rather than a constraint on it.

That leaves a practical question: how should data be connected across a sector as fragmented and varied as adult social care? Two approaches are complementary. Centralised models work well where data is uniform and the use case is national. Federated models, where each organisation keeps its own systems but exposes data through interoperable, standards-based interfaces, fit the operational reality of adult social care. Both depend on suppliers building to common standards and on an open, vendor-neutral coordination layer that connects existing systems dynamically rather than forcing wholesale upgrades. Industry is well-placed to lead in the federated layer because operational data already resides in supplier-built systems.

It also raises a wider question about what counts as evidence of good care. As prevention shifts to remote oversight, sensor alerts and predictive risk signals, the sector needs a shared understanding of what an auditable digital care trail looks like: alert logs, decision trails, and escalation histories that enable automated risk reduction and proactive intervention to count as legitimate care activity. Where commissioners can audit that trail, they have a stronger basis for moving from commissioning by hours of care to commissioning for the outcomes a buyer sets.

Case study

Archangel with Bield Housing and Care

The challenge

Retirement housing providers face a familiar combination of pressures: rising operational costs, a strengthening regulatory expectation that homes are safe and energy-efficient, and a need to identify and respond to issues affecting tenants earlier than reactive models allow. Bield Housing and Care wanted to test whether a sensor-based monitoring approach could deliver measurable benefits in tenant safety and operational efficiency at one of its retirement developments, and whether the model would generate a return on investment robust enough to justify wider rollout.

What we did

We worked with Bield Housing and Care and the Digital Health and Care Innovation Centre (DHI) on a six-month project at Langvout Court in Biggar, South Lanarkshire. The project, entitled Evaluating care delivery in rural settings, was funded by the UK Government's Department for Science, Innovation and Technology (DSIT) as part of the Glasgow City Region 5G Smart and Connected Places Programme. Sensors were placed around communal spaces and ten individual properties to monitor conditions, including temperature, humidity and motion. Data was relayed in real time to Archangel's ambient assisted living platform via the Angelnet resilient connectivity network, with automated 24/7 monitoring used to proactively address any potential issues affecting tenants' living conditions. The data was available to all stakeholders through the Archangel platform. The project was independently evaluated by Edinburgh-based digital technology consultancy FarrPoint.

The outcome

The FarrPoint report demonstrated five areas of measurable impact: reduced utility costs, reduced maintenance costs, reduced manual checks, improved tenant safety and improved regulatory compliance. The project delivered an annual £7,670 saving in heating costs and an annual £2,825 saving in maintenance costs at Langvout Court, with a return on investment within the first year. FarrPoint estimated that, if applied across all of Scotland's retirement housing developments, the model could deliver an annual saving of £18.5 million.

Gavin Wright, Head of Property Management at Bield, said: "This project demonstrates how thoughtful innovation can support older people to live independently, safely and with dignity. The smart technology we trialled at Langvout Court has brought clear cost savings and improved safety. As a result, we're now exploring how this approach can be rolled out across our wider estate."

2.2 Service-Led Redesign and Commissioning

Adult social care modernisation programmes to date have largely focused on kit replacement, which has been a necessary foundation. The next-stage opportunity is service redesign. Digital tools layered onto unchanged services produce digitised inefficiency. Services redesigned around what digital makes possible produce materially different care. This is where industry has the most to contribute. Suppliers see how their tools perform across hundreds of deployments, understand where existing processes create friction, and have a direct commercial interest in solutions that work. That combination of operational visibility and incentive makes the industry an essential partner in redesign, not just a vendor of the systems that sit underneath it.

Outcomes-based commissioning is the principal mechanism for service-led redesign: commissioning by hours of care rewards activity, while commissioning by outcomes rewards results. What counts as a useful outcome is for the buyer to set; the industry's role is to design and deploy towards it and to offer the operational evidence that helps commissioners refine what they ask for over time, recognising that the outcomes that matter on day one are not always those that matter five years in. The shift also requires commercial, digital, data and service-design expertise, confidence in measurement frameworks the sector has not yet standardised, and a tolerance for risk-sharing that current contracting rarely supports.[5] For it to work, suppliers must be honest about what their tools can and cannot deliver: clear about which outcomes are realistically measurable, where the evidence base is still developing, and resisting the temptation to over-claim.

Current commissioning specifications often carry strong ambition that does not translate into delivery, specifications can feel outdated against the technology available, and requirements occasionally describe capabilities that do not yet exist. A shared commissioning-outcomes template, developed openly between commissioners and industry, would help. It would speed up tender writing, make procurement more consistent across authorities, and give suppliers a clearer basis on which to respond.

Strengthening commissioning capability is one of the highest-value changes available, and a practical way to do so is to shift where the conversation between commissioners and industry takes place. techUK has a clear convening role here, bringing commissioners and industry together in neutral spaces to develop and stress-test problem statements before they reach tender, so procurement starts from a shared understanding of the outcome being sought rather than from a feature list. This is the kind of pre-procurement work that makes specifications clearer, gives commissioners access to the breadth of supplier insight without favouring any one provider, and surfaces practical constraints before they become contractual ones.

The contracting routes to support this already exist: pre-commercial procurement, innovation partnerships and outcomes-based frameworks all permit it.[5] Local Government Reorganisation is the natural moment to build these approaches into new authorities from the outset, rather than retrofitting them into established ones.[12]

Case study

Rethink Partners - DHACT programme with the Royal Borough of Greenwich

The challenge

The Royal Borough of Greenwich, like many areas, faced sustained pressure across adult social care and the NHS: rising demand, increasing complexity, workforce capacity constraints and a growing reliance on reactive interventions. Traditional telecare and assistive technology services were largely transactional and siloed, with limited integration into everyday social care or health practice. Residents were experiencing avoidable escalation into crisis or higher-cost care, practitioners lacked timely insight to act earlier, and system partners were unable to consistently evidence the preventative value of technology. Discharge pathways, reablement and frailty services were under particular strain. Greenwich wanted to move away from treating technology as a referral, towards a digitally-enabled service model that genuinely supported strengths-based practice, prevention and integration with NHS partners.

What we did

Rethink Partners has worked alongside Greenwich for more than three years, spanning discovery, design, mobilisation and live delivery support, in partnership with Oxleas NHS Foundation Trust and NHS South East London ICB. Together we launched the DHACT (Digital Health and Care Technology)

programme, which operates borough-wide and supports adults across multiple pathways including hospital discharge, frailty, mental health, reablement and longer-term social care. It is jointly funded across health and local government, reflecting a shared ambition to reduce avoidable demand on both systems through a shared intervention.

Rather than deploying new technology into an unchanged system, we redesigned how care is assessed, delivered and monitored, with digital tools embedded into everyday practice. Key elements of the intervention included co-production with residents, carers, frontline social care staff, NHS colleagues and commissioners to shape pathways, assessment approaches and use cases; a bottom-up redesign of the service model, starting with practitioner workflows, decision-making and outcomes rather than devices; development of a single, integrated digital care technology operating model covering referral routes, assessment, installation, follow-up, monitoring and escalation across health and social care; the integration of care technology and data for prevention into mainstream social work and health practice; a sustained culture change and capability-building programme including immersive training, coaching and skills transfer; and a robust benefits and financial modelling framework aligned across the council and NHS partners.

The outcome

Within the first ten weeks of mobilisation, referrals and installations exceeded initial projections. Eighty-seven per cent of staff completed immersive DHACT training, reflecting strong workforce engagement. Greenwich developed and adopted a financial and benefits model projecting £36 million of net benefit over ten years, with breakeven by Year 2, giving commissioners and system leaders the confidence to invest and scale. Practitioners report improved confidence in assessment and risk management, stronger personalised conversations with residents, and a greater ability to intervene earlier. Residents and families report improved reassurance, safety and independence through more responsive, joined-up support. DHACT has moved from being a bolt-on offer to an embedded system capability, providing a meaningful lever for bringing health and care integration to life. Technology enabled the change by giving practitioners visibility between visits and supporting proactive decision-making, but it was the redesign of practice and workflows that unlocked value.

Service redesign of the kind Greenwich describes works best where the underlying data infrastructure can support it. Where commissioning systems remain siloed or rely on manual workarounds, the friction of moving information between them quickly absorbs the gains from even well-designed pathways. The next example shows what becomes possible when the infrastructure is deliberately joined up.

Case study

The Access Group - Mosaic, Adam and Assure with Derbyshire County Council

The challenge

Derbyshire County Council delivers social care across one of England's largest counties, supporting vulnerable adults, children and families through children's services, adult social care, youth justice and early years provision. Despite existing digital investment, teams were using the same platforms in inconsistent ways. The result was administrative duplication, insecure data transfers and less time available for direct resident support. Tracking self-funded packages was close to impossible: when packages closed or clients moved, the team had no visibility, and when team leaders were absent, colleagues could not replicate the same processes, creating a consistent risk to service quality. As Corrina Bailey, Group Manager for Contracting and Compliance, summarised: "We discovered that we were really data rich. However, the challenge was providing consistent information to both our internal teams and external providers in a way that supported strategic planning."

What we did

Derbyshire chose to transform commissioning by connecting systems rather than replacing them. As an early adopter of Access Mosaic for case management, the council partnered with us to integrate Access Adam Care Commissioning directly with Mosaic, creating an end-to-end digital pathway

from initial assessment through to commissioned care. A brokerage request raised in Mosaic now triggers an automated workflow step that passes a corresponding task directly into Adam, where the brokerage team picks it up immediately and key information transfers across without manual handling. Where individual circumstances require it, caseworkers can adjust details by hand, preserving personalisation within a standardised, auditable process. Security was a direct design requirement throughout: no cross-system data sharing via email, no risk of interception in transit, and no manual re-keying introducing errors or compliance exposure.

The outcome

Average commissioning time, from referral to care in place, has fallen from three days to two. The proportion of care offers received within two hours of posting has increased by around 20%. Manual spreadsheets and insecure email forms have been eliminated from the brokerage process. The council now has full visibility of self-funder packages that were previously untraceable.

The strategically most significant outcome is what the data now enables. Adam's analytics layer gives Derbyshire visibility of package volumes by district, average sourcing speed, provider response rates and self-funder activity. Derbyshire is now twelve months into sharing commissioning data directly with external providers, enabling them to model demand, plan capacity, and build investable business models. Some providers are actively building business plans around the intelligence the council supplies. This is the commissioner-provider collaboration that national policy encourages but rarely materialises in practice, primarily because the data has not previously existed in accessible, structured form.

2.3 Workforce, Culture and Digital Capability

The adult social care workforce in England is approximately 1.6 million people, with a vacancy rate around 7%, roughly 111,000 vacancies on any given day.[13] Whether digitally enabled adult social care succeeds is ultimately a question about the workforce: whether technology is designed to support their judgement, redesigned around their workflow, and accompanied by the time, training and confidence to use it well.

The British Association of Social Workers' 80:20 campaign calls for social workers to spend at least 80% of their time on direct work with people rather than administration.[14] It's a useful lens for thinking about digitally enabled services. Technology designed to augment professional judgement supports retention, frees time and improves practice. Technology that monitors or replaces judgement does the opposite.

Where digital tools are co-produced with frontline staff and reduce administrative burden, adoption follows. Where they are imposed on top of existing workload without redesign, they are quietly worked around or abandoned. Co-producing tools with the workforce, rather than building for them and rolling out to them, is something suppliers can lead on.

Digital confidence across the workforce is uneven. Skills for Care's Workforce Strategy recommendations (piloting a "care technologist" role, a CPD strategy, and expanded digital skills training) should be prioritised.[13] Industry has a complementary role: onboarding and training that goes beyond product induction, accessible support for frontline staff, and partnerships with training providers where appropriate.

Digital and data capability should be built into inductions, qualifications and CPD rather than treated as bolt-on upskilling. As AI becomes more present in everyday practice, care workers need to be confident in using it and equally confident in interrogating its outputs. A workforce that defers to AI without question loses precisely the professional judgement that adult social care depends on. Curriculum and CPD frameworks should treat critical thinking, ethical reasoning and the ability to challenge automated suggestions as core competencies.

Thought leadership

If AI is the answer, then what is the question? Defining intelligent care for the AI era

Stef Lunn, Social Work Practice Lead, Civica

Just like millions of people in the UK, I am an informal carer. My Dad needs help with some day-to-day tasks and I am glad that I can be his main supporter. I am also a registered social worker, so I have a good understanding of the care system. For the last eight years, I've been working in care technology, exploring how digital case management can make social workers' lives easier. Of course, AI is a current hot topic.

These three worlds; caring, social work and technology, came together recently when I was offered the chance to try out a new AI-enabled carers assessment tool. I was intrigued to see how it would work for me. The AI assistant called at the time I had requested and asked me several questions. I didn't really know what to expect, but it was an unexpectedly positive experience. In conversation with a person, I would tend to filter information for the avoidance of any judgement. But as the assessor wasn't a person, it just felt a little bit more freeing, enabling me to be more direct about our situation and my feelings.

With my social worker's hat on, I was satisfied with the follow-up guidance and support that has been offered. And from a technology user's point of view, I was pleased with the overall user experience.

This is a very specific product, targeted at offering earlier support to carers who would otherwise be just waiting for an allocated worker. What marks this out from much of the debate is that clear mission.

As a sector, we don't yet know where we should be heading with AI. Within local authorities AI policies are often in need of development, but even before refining operational policy, organisations need a clear mission.

We often hear the vague stated aim to the effect of "let's do it quicker, let's do it better".

From a productivity standpoint "let's do it quicker" is measurable. For example, the length of time spent writing assessments can be reduced by X-amount. As a sector we are less clear about what 'better' looks like.

Part of the problem is that we're lacking robust research into the views, needs and preferences of citizens who will use and hopefully benefit from these AI tools.

We know that people value having a relationship with their social worker. They value the opportunity to build that understanding with a consistent worker. That seems a sensible, ethical guiding principle for AI strategy. With the current focus on 'test and learn' approaches in AI, this might be a benchmark for 'better' to sit alongside those measurements of speed.

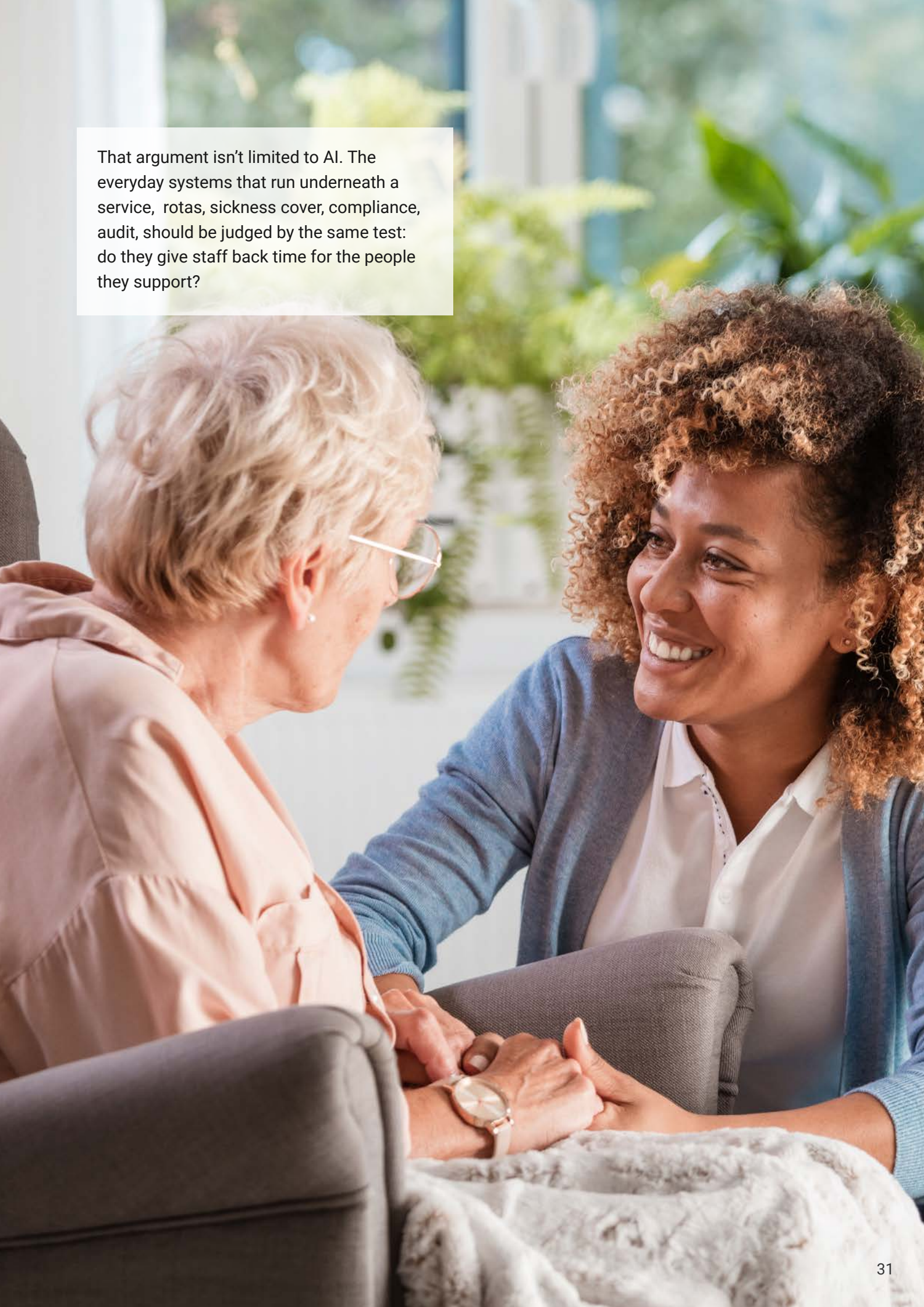
There is a fear among social workers that if efficiency savings demonstrate someone can generate their reports and recording twice as fast, then they're just going to end up with double the work, rather than more time with people. That is what we should be trying to avoid.

This approach is encapsulated by the British Association of Social Workers' 80:20 campaign. People are drawn into social work because they want to make a difference to people's lives, but then they spend 80% percent of their time on administration. Their work on AI has focused on using efficiencies to support relationship-based practice.

If AI is the answer, then it should be deployed with the purpose of unlocking more time for relationship-based social work.

Without setting a clear, unified mission for AI deployment that works for both citizens and service providers, it's going to be much more challenging to ensure that the sector can keep pace with the technology in an appropriate way.

That argument isn't limited to AI. The everyday systems that run underneath a service, rotas, sickness cover, compliance, audit, should be judged by the same test: do they give staff back time for the people they support?



Case study

CoolCare with a multi-site adult social care provider

The challenge

An adult social care provider supporting individuals with complex needs across four residential homes in England was experiencing significant challenges with workforce visibility, operational control and administrative efficiency. Rostering systems did not accurately reflect actual staffing levels or agency usage. Workforce data was difficult to access in real time, making it hard to manage holidays, sickness and staffing costs. Communication, HR tracking and reporting all relied on time-consuming manual processes. Preparation for compliance and QA audits was slow, and there was no structured oversight of occupancy pipelines and enquiry management. The cumulative effect was reduced management control across the homes, increased administrative burden on already stretched teams, and limited ability to optimise staffing or occupancy.

What we did

We implemented CoolCare across the organisation to support workforce management, administration, compliance and occupancy processes. The deployment enabled a redesign of several core workflows. Workforce and rota management moved to a digital system with real-time visibility into staffing, holidays, and sickness, removing manual holiday requests. Communication

and shift coordination shifted to an integrated messaging system linked to rotas, allowing direct communication with staff to manage shift cover and updates. HR, compliance and audit preparation were centralised, with the majority of audit information available in one system. Occupancy and enquiry management gained structured tracking of enquiries and pre-assessments, alongside increased accountability across managers and heads of department. Finance and payroll processes were simplified, with more accurate financial data.

The outcome

Preparation time for QA audits has fallen by approximately one full day, with around 70% of the required information now available directly from the system. The integrated messaging system has saved several hours per week previously spent on phone calls. Real-time tracking of rotas, holidays, and sickness has improved workforce data accuracy and reduced errors. Payroll, invoicing and financial processes have become simpler and more accurate. Improved visibility of enquiries and increased accountability has supported an increase in occupied beds. Managers and senior staff can act more quickly on staffing and occupancy issues. Overall, the changes have delivered stronger operational grip across the homes, reduced administrative burden, and increased confidence in the data underpinning operational decisions.

2.4 Inclusion, Co-Production and Lived Experience

Digital inclusion in adult social care is often framed as access: device, connection, basic literacy. These matter, but the deeper question is whether digitally enabled care works for the people who draw on it.

Co-production is increasingly referenced in strategies, frameworks and procurement specifications, and the next step is making sure it is consistently evidenced in practice. The opportunity is to ensure lived experience input is structured into the design of the technology and services that shape people's lives, so that products are designed with people rather than for them.

Responsibility for changing this is shared, but the practical work of embedding lived experience in product design sits with industry. Suppliers can treat co-production as part of design, record how that input shaped the product, and welcome commissioners who require evidence of it. The evidence presented should be proportional to the supplier's size. For a large vendor, this might include standing user panels and formal design logs. In contrast, a smaller vendor could simply demonstrate that real users influenced the product and that their feedback was acted upon. The aim is genuine involvement, not documentation for its own sake, so requirements do not become a barrier, falling hardest on smaller innovators.

People need to trust that the technology used in their care is safe, clear and designed to support them. They should have a real choice in how digital tools are used, including non-digital options where those work better. Most importantly, digital tools should support, not replace, relationships with care workers, social workers and family carers.

The most underused source of lived experience is the unpaid carer. Around 5.8 million carers across the UK provide care that the formal system relies on, and they know what works at home, what fails, and where the gaps are. That insight is rarely structured into procurement, supplier development, or treated as the operational expertise it is. Building carer voice into co-production is one of the cheapest and most effective changes the system can make, and one industry can act on directly: through carer panels feeding product roadmaps, testing new features with carers alongside paid staff, partnerships that reach a more diverse group, and feedback loops that carry carer insight into the next development cycle rather than a one-off consultation.

Thought leadership

From data to decisions - power, pitfalls and perspective

Angus Honeysett, Market Development Director, Tunstall, and Chair of the techUK Social Care Working Group

This case study is personal. It's about me. I'm Angus, and I've been living with type 1 diabetes for 37 years.

Over the last six weeks, I've started using the Libre continuous glucose monitoring (CGM) system. After decades of managing my diabetes in a more traditional way, this shift to something far more data-driven has been both eye-opening and, at times, really tough. I went into it expecting clarity, better control, and a more data-driven approach to my condition. What I didn't fully expect was just how confronting, and at times overwhelming, that level of insight would be.

Before using Libre, I managed my diabetes using regular finger-prick tests and a lot of experience-driven, educated guesswork. I had a general sense of patterns, but there were always gaps in my understanding and times when I simply didn't know what my blood sugar was doing. The CGM has removed the gaps almost instantly. Suddenly, I could see my glucose levels in real time, along with trends, spikes, and drops that I previously would have missed entirely.

At first, and remember this only started six weeks ago, it felt empowering. I had more information than ever, and I believed that would quickly lead to better control. In reality, the first few weeks were some of the hardest I've experienced in a long time. The data didn't just highlight the good and what was going well, it's highlighted every fluctuation, every miscalculation, and every unpredictable response my body has to food, exercise, and insulin.

I've found myself dealing with high and low blood sugar, often in quick succession. Meals I thought I understood caused unexpected spikes I didn't expect. Corrections sometimes led to overcorrections. Even routine activities turned out to be more unpredictable than I realised. It quickly became obvious that having more data doesn't automatically mean knowing what to do with it and despite living with diabetes for 37 years, I've had to relearn parts of it all over again.

Emotionally, I've also found this period quite difficult. Seeing constant evidence that my levels weren't where I wanted them has been frustrating. There's a mental weight that comes with continuous visibility and you're never really "off duty." At times, it's felt like I'm chasing the numbers rather than managing them and when my diabetic nurse said things might get worse before they got better, it wasn't what I wanted to hear, but they were right.

However, over the past couple of weeks, things have started to shift. Patterns that once seemed chaotic are beginning to make sense. I've learned how my body responds more precisely to different foods, timing of insulin, and activity levels. I've adjusted insulin doses based on readings instead of reacting to every data point, I'm starting to interpret trends and make more measured adjustments. My glucose levels are stabilising, with more time spent within target range and fewer highs and lows. The progress hasn't been immediate, but it's meaningful and sustainable.

The biggest lesson for me is that better control is not immediate, it's iterative. The technology hasn't magically solved my diabetes, but it has given me the tools to understand it more deeply. With that understanding comes the ability to make more informed decisions, even if it takes time to get them right. Now I'm seeing more stability. My glucose levels are spending longer within target range, and the highs and lows are becoming less frequent. It's still not perfect, but it's progress, and more importantly, it feels sustainable.

This experience has reinforced that managing type 1 diabetes is as much about learning and adapting as it is about discipline. The technology is powerful, but it requires patience, resilience, and a willingness to engage with the data over time. It's been hard work, but it's starting to pay off, and that makes the journey worthwhile.

Beyond my personal experience, this journey highlights a broader opportunity. The combination of continuous data and intelligent interpretation has significant potential in supporting people to live independently at home for longer. With the right systems in place, CGM data can provide early insights, identify risks, and enable proactive interventions. It shifts care from being reactive to preventative, offering both improved outcomes and greater confidence for individuals and their support networks.

More broadly, the benefits of using technology like CGM are significant. It changes the game from reacting to problems to actively managing them with insight and confidence. Instead of relying on snapshots and guesswork, a continuous, living picture of what's happening. That means earlier intervention, fewer surprises, and better long-term control. It doesn't remove the effort of living with diabetes, but it makes that effort more effective.

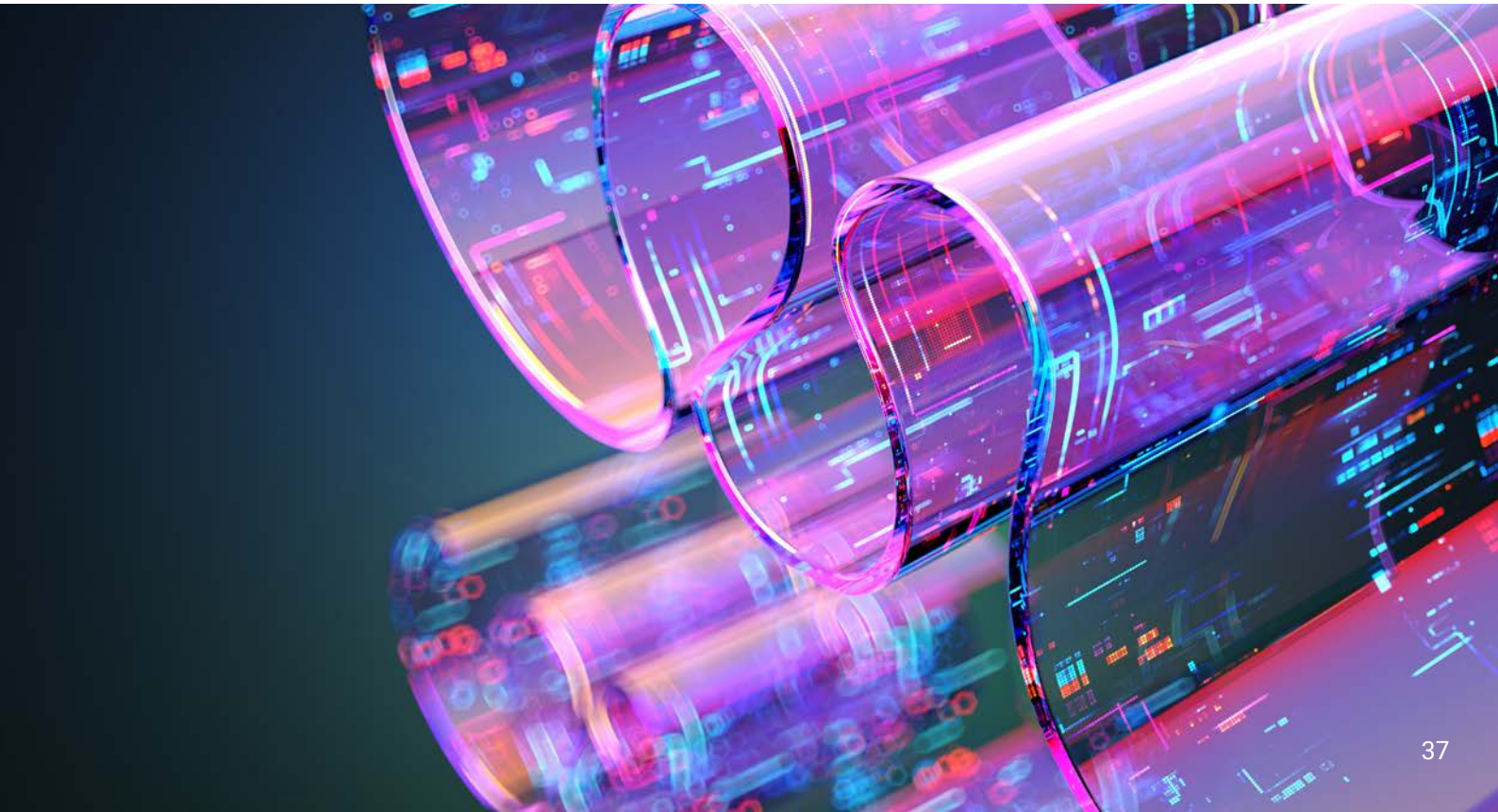
Over time, that translates into fewer risks, greater stability, and a real sense of control. For me, and for many others, that shift is powerful, not just clinically, but in how you live your life day to day.

2.5 Data and AI as Operational Infrastructure

AI is becoming one of the most important enabling technologies in adult social care. Some of the highest-value applications are those that run in the background (decision support, predictive risk stratification, ambient and acoustic monitoring, rota optimisation, voice-to-text and structured-record automation), adding to the judgement of the workforce rather than overriding it.

Looking ahead, agentic AI is starting to reshape the front door. Unlike conventional chatbots, agentic systems carry out sequences of tasks autonomously: asking follow-up questions, pulling information from different systems, completing forms and routing enquiries to the right team. Early applications include first-contact triage, signposting and structured information-gathering ahead of assessment, with potential to change how people access support and how routine cases are handled.

How AI is deployed matters as much as what it does. Capabilities built into existing case management systems inherit the data governance, access controls and audit arrangements already in place, the fastest and safest route to adoption at scale. Bolt-on tools need separate governance and integration work, but bring specialist capability and pace of innovation that embedded systems cannot. Both routes matter: close either off and the under-pressure workforce turns to consumer-grade generative AI for tasks the formal system does not yet support, with real data-security implications. The answer lies with commissioners and system leaders, supported by clear national assurance and a responsive supplier market, in ensuring approved, secure alternatives are available where needed.



Case study

Ally Cares - AI-enabled night-time monitoring across UK care homes

The challenge

Adult social care is expected to prevent avoidable hospital admissions, support neighbourhood care and relieve system pressure while delivering personalised support. Yet one of the most consequential periods of care delivery, the night, has been underexamined in redesign conversations. Routine night-time checks have long reflected a culture of vigilance, but without clear insight into sleep and movement patterns, tailoring intervention to individual needs has been difficult, and residents have at times been disturbed while resting safely. Sleep disruption is clinically significant: fragmented sleep increases falls risk, contributes to delirium, weakens immune response and affects mood and mobility. For people living with frailty or dementia, restorative sleep underpins resilience and stability.

What we did

We deploy AI-enabled resident monitoring using sound and motion sensors, providing live insight into sleep and movement without physical intrusion. The technology came alongside a redesign of practice: rather than blanket checks, teams respond to risk indicators. Sleep and movement trends are reviewed during handovers, and objective data informs falls prevention and medication-review

decisions. Governance frameworks addressed consent and data protection from the outset. Staff were trained to interpret patterns and escalate appropriately, strengthening professional judgement rather than substituting for it. The model is operating across more than 6,000 resident bedrooms in England.

The outcome

In one independent care home group, a comparison of the twelve months before and after implementation showed an 84% reduction in high-risk falls, driven by identifying early changes in movement and sleep that signalled rising risk. In another setting, sleep data gathered over several months supported structured medication reviews: residents prescribed long-term sleep medication were reassessed using objective trends, and with clinical oversight medication was reduced for several individuals without deterioration in sleep quality. Across multiple homes, residents were recorded as waking up to 50% less frequently at night, with improvements in daytime engagement and wellbeing.

The aggregate picture across the homes using the system, as of 2026, includes more than 10 million hours of safer care delivered; over 2 million additional hours of uninterrupted sleep for residents; more than 4,100 falls prevented; and over 330,000 hours of time redirected back to frontline care staff. Baseline outcome data demonstrates an average 63% reduction in falls, 56% fewer hospital stays, a 50% increase in sleep continuity, and 30% more direct care time available to staff. More than 2,000 additional bedrooms have been installed nationally, extending digitally enabled night-time prevention across residential and dementia care settings.

Users of AI also need to understand why a tool reached its conclusion. Tools should be designed so reasoning is interrogable in the moment, expressed in terms that match how decisions are made, and accompanied by clarity about limits and confidence levels. The same principle applies whether AI runs quietly in the background or sits actively alongside the practitioner.

Case study

System C - FormFlow AI Assistant with Suffolk County Council

The challenge

For social care practitioners, having sensitive conversations and observing environments in people's homes is critical, but managing talking, writing and recalling details all at the same time is a real challenge.

Toni Backler, a Senior Independence and Wellbeing Practitioner at Suffolk County Council, described how this disrupted the flow of assessments and reduced her sense of connection with the individual. Conversations often paused while notes were written. In some safeguarding and domestic abuse assessments, individuals were particularly sensitive to the practitioner writing things down. Home environments often made physical notetaking even harder, with cramped or cluttered settings forcing practitioners to hold paperwork and equipment while moving around. High caseloads added to the pressure.

As Toni explained: "Our caseloads can be quite high at some points; some staff could be holding 26 cases at one time that are all very similar, and that is really challenging." Without detailed notes captured in the moment, cases could blend together. After visits, some social workers had to sit in their cars and record verbal summaries to avoid forgetting key details, and writing up complex assessments often took several hours.

What we did

Suffolk County Council ran a proof-of-value pilot of FormFlow AI for five months to evaluate how AI could support frontline practice, reduce administrative burden and improve the quality and timeliness of assessments. Practitioners, with the consent of the person being assessed, could start an audio recording at the beginning of a visit. As they moved around the home they could talk naturally and explain what they were observing. After the visit, FormFlow produces a transcript organised into assessment sections, reducing reliance on memory and removing the need for workers to record summaries after hours. The write-up stage allowed the practitioner to remain in control of the information and remain responsible for the analysis and decision-making.

The outcome

A study conducted during the pilot phase found a 67.9% reduction in the time taken to complete forms, across all completed form types. Assessments that previously took hours now took a fraction of the time.

As Toni put it: “For me as a practitioner, write-ups that used to take hours now take a fraction of the time. I no longer need to do my brain dumps in the car. I feel less mentally drained because I’m not juggling multiple tasks at once. Assessments feel more person-centred and meaningful.”

People felt more comfortable because they were not watching the practitioner write or type; practitioners stayed focused on the interaction, maintained eye contact and picked up on non-verbal cues. Conversations felt more natural and required fewer pauses, which was particularly helpful in sensitive assessments involving domestic abuse, dementia or mental capacity. Practitioners who found written documentation challenging, including those with dyslexia, found the transcripts particularly helpful. Remaining fully present in the assessment also improved safety: workers could observe early signs of distress or confusion and respond appropriately, which was particularly important in assessments involving people living with dementia. Across the wider service, documentation became more accurate and timely, practitioners could submit assessments sooner, information shared with multidisciplinary teams became clearer, and workers covering duty or supporting colleagues could quickly understand cases using the detailed transcripts.

Four governance principles are non-negotiable. First, human-in-the-loop for any decision affecting care, support or safeguarding, with the boundary between advisory and determinative use clearly defined. Second, active bias management: historic social care data records the thresholds, decisions and structures of the system as it has operated, and AI trained on that data inherits those structures by default. Unmanaged bias falls hardest on the groups least well served.[5] It cannot be fully eliminated, but it can be identified, documented and managed across the lifecycle. Third, AI is only as good as the data feeding it: where demographic and clinical records are incomplete, inconsistent or carried over imperfectly from paper-based legacy systems, AI will inherit and amplify those problems. Data sharing and interoperability matter, but quality must be treated as an explicit requirement alongside them. Lastly, proportionate post-market surveillance, calibrated to the risk profile of each tool, recognising that AI systems evolve through model drift and changing contexts.[15]

Standards need to be adaptable as well as rigorous, covering not only data and interoperability but the process of using technology in practice: how decisions are made with AI in the loop, how oversight is exercised, how concerns are escalated. The cumulative load of the assurance landscape is itself worth addressing, with overlapping regimes across the Care Quality Commission (CQC), the Digital Technology Assessment Criteria (DTAC), the Data Security and Protection Toolkit (DSPT), the Medicines and Healthcare products Regulatory Agency (MHRA), ICB-level and local trust-level processes falling most noticeably on the SMEs.[16] [17] Streamlining this without weakening protections is something industry, regulators and government can usefully take forward together.

2.6 Industry Collaboration

Industry is part of the system described here, and the changes called for cannot happen without active engagement and willingness from the supplier community. The principles the supplier community can engage with (open standards, published integrations, more outcome-aligned commercial models, and ecosystem partnerships) are increasingly visible in how mature suppliers are positioning themselves.

No single supplier can deliver the digitally enabled adult social care that the 10-Year Plan depends on. Delivery requires an ecosystem in which large suppliers, SMEs and VCSE partners each play roles that the others cannot. SMEs bring lots of innovation, larger suppliers bring the integration capability, operational reach and customer relationships needed to scale that innovation. The VCSE sector brings the community trust and inclusion expertise that determines whether technology reaches people.

No single element can replace another. The aim is a lively marketplace where all can prosper, and new entrants can find a way in. That depends on a few things. Standardised, reusable integrations so large suppliers do not need to build custom connections to each SME, and SMEs are not priced out of integration. Proportionate, reusable assurance that genuinely reduces paperwork, since smaller suppliers carry the heaviest regulatory load. Clear, well-documented integration pathways for SMEs into platform offers, and larger suppliers actively bringing SMEs into their supply chains, with SMEs building products that integrate cleanly into wider platforms.

Shared sandboxes are the practical environment in which much of this comes together. They allow SMEs to test new products against real data and real workflows, give commissioners confidence in what they are buying, and let standardised integrations be tried before scale. The **MHRA's AI Airlock** is one example of the direction of travel.[15] Extending the sandbox approach more widely across adult social care, as a low-risk space for innovation and pre-procurement testing, is one of the most useful things national and local bodies can do to support a healthy supplier ecosystem.

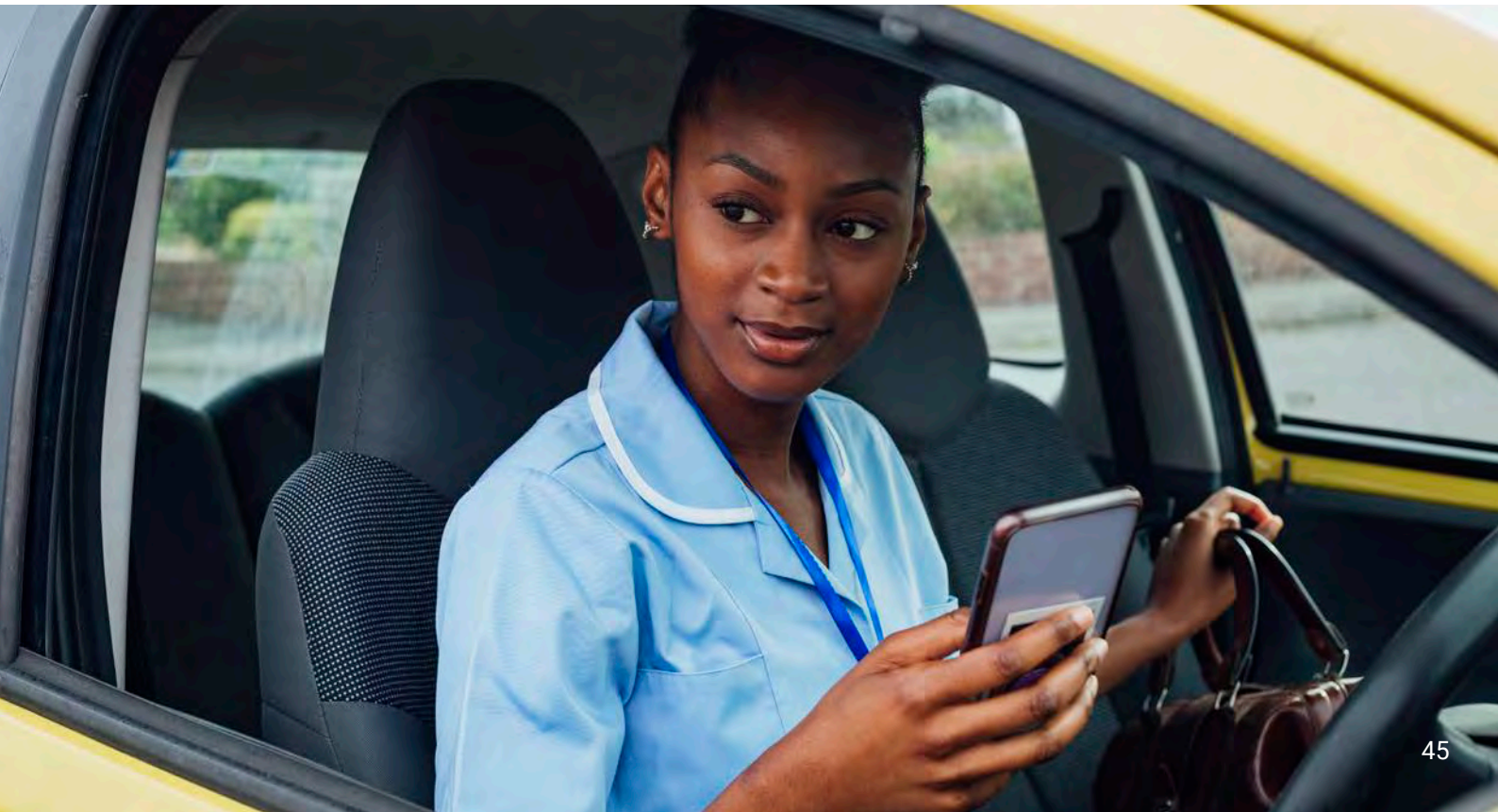
The commercial models that have shaped adult social care to date are mostly transactional: suppliers are paid for devices, licences or installation, and the relationship largely ends once deployment is complete. This has supported widespread adoption and reflects what commissioners have largely asked for. Across the sector, there is a broader conversation about how commercial models might evolve over time, including more outcome-aligned approaches, as the sector matures. Any such shift depends on collective work that is still in progress, including agreed definitions of which outcomes matter for which use cases, and methodologies for measuring them that all parties can rely on. Industry has a useful contribution to make to that conversation, through the deployment evidence suppliers already hold and through ongoing dialogue with commissioners on what is realistically measurable today and where the evidence base will develop next. A vibrant marketplace depends on the buyer side being clear about what it wants, articulating the outcome being bought, the constraints, and the requirements of the tool, and doing so early.

Chapter 3: The Path Forward

The opportunity to align the four converging forces is narrow. The recommendations below set out how different parts of the system can seize it. None depends on new technology. All depend on deliberate choices about how the system is funded, commissioned, assured and held to account.

These recommendations have funding implications. They are not primarily a call for a larger overall funding envelope, although additional investment would bring significant benefits. They are a call for existing funding to be redirected and pooled more effectively, so prevention investment reaches the parts of the system where it delivers the greatest impact, and so mature technologies can be deployed at scale within the resources already available.

Above all, the sector needs a clearly defined route map: a strategy and an action plan, backed by concerted, coordinated leadership at national, NHS and local authority levels. Successive governments of both major parties have struggled to translate intent into delivery on the combined challenges of health and social care,



and the system has effectively been left without sustained coordinated leadership across both. Closing that gap is the precondition for everything in this chapter.

It also sets out the principles by which industry, including techUK members, can engage alongside the rest of the system: a framework for partnership that describes how the supplier community can contribute to the changes set out in the rest of this paper.

3.1 National Government

- A clear interoperability mandate for adult social care, covering minimum viable data sets, open APIs, shared standards and data quality, developed with industry as well as government, so the standards are ones suppliers can meet.
- A reusable assurance regime, proportionate and machine-readable, recognised across CQC, DTAC, DSPT and MHRA where applicable, paired with practical guidance on data sharing, AI governance and accountability.
- Ring-fenced multi-year digital funding for adult social care, paired with the Better Care Fund and explicitly available for service redesign rather than only kit replacement, with a horizon that exceeds a single political cycle.
- A national career pathway for technology-enabled roles in adult social care, supported by funded training, progression routes and qualifications, developed in step with whichever workforce strategy is in place so it outlasts a single strategy cycle.
- A long-term funding and accountability settlement that pulls NHS and local authority money together for prevention, with mechanisms to recognise where savings actually accrue across the system.

3.2 Local Authorities

- Commission for outcomes using flexible, equipment-agnostic procurement, with investment in commercial, digital, data and service-design expertise.
- Embed digital and co-production into LGR transition plans from the start.
- Pool NHS and local authority prevention funding at the regional and neighbourhood level, using existing Section 75 and Better Care Fund flexibility, so investment lands where the savings accrue.
- Build evidence of co-production with people drawing on care, including unpaid carers, into procurement practice.
- Establish early market engagement as a core element of normal commissioning practice.
- Test whether digital requirements create a real operational benefit for care providers, not only a system-level benefit elsewhere, and recognise in funding and commercial models where the costs and benefits of integration fall across the system.

3.3 Strategic Authorities

- Work alongside local authorities and ICSs on long-term, place-based planning that anticipates the evolving needs of the regional population and the services those needs will require.
- Take a coordinating role in market shaping, working with industry and the VCSE sector to

ensure supplier adequacy across the region, particularly in areas where market thinness limits choice for commissioners and people drawing on care.

- Convene cross-boundary work on infrastructure that underpins community-based care, including connectivity, housing, transport and workforce supply.
- Use the regional vantage point to align digital and data strategies across constituent local authorities and ICS partners, reducing fragmentation in standards, procurement approaches and assurance expectations.

3.4 NHS, ICSs and ICBs

- Position adult social care as an equal system partner in the design of integrated care, including in upstream demand management as well as discharge.
- Develop jointly agreed digital strategies across all stakeholders with shared outcomes, data architecture and clear cross-system accountability.
- Pool prevention budgets across the NHS and local government at neighbourhood level.
- Embed adult social care into ICS digital programmes (interoperability, single patient record, neighbourhood health) as an integral partner in design and delivery.
- Involve care providers, including independent-sector providers, early in the design of interoperability and neighbourhood health programmes, rather than engaging them once requirements are set.
- Avoid adding reporting or workflow burden to care teams unless there is a clear, compensating operational benefit for the provider, and test for this before mandating new digital requirements.

3.5 Industry: Principles for Engagement

The following principles can guide the supplier community as part of the partnership described in this paper. They reflect the direction mature suppliers are moving in and the conditions under which the coordination discussed in the paper is most likely to be built.

It is worth recognising that some of these principles place a greater burden on SMEs than on larger suppliers, and commissioners and other stakeholders should be proportionate in what they expect from different parts of the market.

- Active engagement with interoperability principles, working with government, commissioners and other suppliers to shape the standards the sector adopts, a commitment to implement those standards once developed, and a clear preference for open architectures over closed ecosystems where the choice exists.
- Support for vendor-neutral orchestration models that connect existing digital records, telecare, sensor, housing and care systems into secure, auditable workflows, so commissioners and providers can evidence prevention and coordinated responses across organisational boundaries.
- Visible co-production in product design, demonstrated proportionately to the size and stage of the supplier: evidence that people with lived experience shaped the product and that their feedback was acted on, shown through the product itself and the people involved rather than through documentation

burdens that fall hardest on smaller companies.

- Transparent, consistent digital evidence of care activity, including alert logs, decision trails and escalation histories, so the impact of preventative interventions can be recognised within commissioning and assurance.
- Continued movement towards more open commercial practices, including ongoing review of contractual and architectural approaches that affect data portability and interoperability.
- Ecosystem collaboration, with large suppliers, SMEs and VCSE partners working together through shared sandboxes, partnership-based bidding and clearer routes for SMEs and innovators into platform offers.
- Transparent evidence of outcomes, with suppliers contributing comparable deployment evidence to the shared sector evidence base, supporting the shift to outcomes-based commissioning.
- Workforce-aware design, with tools built to augment professional judgement, reduce administrative burden, and support the shift towards more time on direct care, with onboarding and training treated as part of the product.
- AI designed responsibly with transparent reasoning, active bias management, attention to data quality, human-in-the-loop where decisions affect care or safeguarding, and proportionate post-market surveillance.
- Engagement grounded in the reality of the provider market, recognising that care providers are often the operational adopters and the paying customers, so that integration is designed around a clear benefit to providers and frontline teams, not only the technical feasibility of connecting systems.

3.6 An Invitation to Deliver

techUK's Social Care Working Group brings together techUK members and representatives from across the social care ecosystem to interrogate the challenges facing adult social care and to explore how technology can deliver better outcomes for people, providers and the wider health and care system.

The Group is committed to working in partnership with:

- National government and policy bodies: DHSC, NHS England, MHCLG (Ministry of Housing, Communities and Local Government), and the Treasury.
- Regulators: the Care Quality Commission, MHRA and NICE.
- Local and regional delivery partners: ICSs, ICBs, the LGA, ADASS, care providers and the VCSE sector.
- People drawing on care and the unpaid carers around them.

The Group will continue to convene the sector around the challenges that matter most, advocate for the policy and commissioning changes set out above, evidence what works through case studies and member intelligence, and help shape national programmes. The technology to deliver the 10-Year Plan's ambitions already exists; what remains is the coordination to deploy it at scale.

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