

Digital excellence in care for working age adults

A joint initiative of the Digital Excellence in Care (DEC) group, Care England, Digital Care Hub and VODG

Steering group

This report has been produced under the direction of the DEC steering group, drawing on contributions from Care England, Digital Care Hub, VODG, and participating provider and digital supply partner organisations.



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Foreword

Digital developments are occurring at an ever faster pace in social care. It can sometimes feel overwhelming for front-line staff, people supported and their families. Even senior leaders can struggle to keep up with developments or to know what technology is best for their organisation and the people it supports. Digital developments, including AI, offer the opportunity to greatly improve both the quality of the services that we offer to people supported, enabling them to achieve their hopes and dreams, and to improve the efficiency of organisations that often face a challenging financial climate.

Providers recognised that there is currently a gap in the digital landscape with no clear direction of travel. This report has been prepared to fill that gap. Our aim is to define “good” and to set out a clear roadmap for the future which will guide both care providers and digital supply partners. We hope that it also brings much needed clarity to people supported and their families.

We approached the development of this report in a very collaborative way, not only involving a wide range of provider representatives and digital supply partners, but also the Local Government Association, CQC and Learning Disability England which did a fantastic job representing the views of people supported and their families. We would like to thank all of them and also the members of the steering group who worked hard to prepare this report.

This report has been written for working age adult services where there is a strong history of collaboration. A lot of its contents will also be relevant for care providers and digital supply partners working in other sectors, like services for older people. We hope that you find it useful and thought provoking.

This is, to our knowledge, the first sector-led report of its kind for working-age adult social care. It is the product of a distinctive collaboration between care providers, representative bodies, people drawing on support and their families, public bodies and digital supply partners. We welcome feedback on how the report and its companion tools can develop further to help providers deliver digital excellence.

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Executive Summary

Our aim is to improve the lives of the people we support in a digital world. Technology should give people more control over their support and help them live with greater independence and wellbeing. This report sets out what digital excellence should look like in working age adult social care, and what providers, digital supply partners, commissioners and regulators need to do to achieve it.

To our knowledge, this is the first sector-led framework of its kind for working age adults. It gives people supported and providers a shared voice on what needs to change. We have summarised the priorities as 'TIDES': Transformation, Impact, Delivery, Engagement and Standardisation.

Transformation

Done properly, technology can transform how social care is delivered by giving people more control over their support and helping services respond as their needs change. Accessible tools can help people manage everyday routines and make choices about their care. Sharing relevant information would help care staff, health professionals and other services coordinate support and act on concerns before a crisis develops.

For example, someone who can make their own breakfast may prefer to use their funded support to go out in the evening. The system could update the rota and care record once the change is agreed, so staff can see the revised plan. Recording whether support achieves the person's goals would give commissioners evidence to support a move from time-and-task to outcomes-based commissioning.

Providers, suppliers and commissioners will need to change how they work. The report covers eight connected areas: Families, People we support, Finance, Commissioning, People (the workforce), Regulatory assurance, Estates, and Quality & improvement. Many providers already use digital care records, but separate systems, repeated data entry and costly bespoke integrations limit what they can do with the information. When someone's support changes, the relevant staffing, funding and risk information should change with it, with as little repeated data entry as possible.

Impact

People should be able to understand information about their care, express their preferences and see them reflected in everyday support. The test is whether their support improves their quality of life and helps them achieve their goals. Family involvement should follow the person's choices and the agreed arrangements for access to information. Accessibility, consent and privacy need to be built into systems from the outset.

Less time spent on repeated administration should leave staff more time for people. Linking care, staffing, medication and incident information should help teams spot concerns earlier. Better financial and property information should help providers plan, while quality information should show boards whether services are learning from problems and making lasting improvements. These are expected benefits and must be tested in practice. Staff and managers remain responsible for decisions. Technology should support independence without reducing human connection.

Delivery

The Data Maturity Model helps providers judge where they stand in each area, from Siloed through Standardised and Optimised to Actualised. Providers can use the requirements and diagrams to decide

which changes to make first. They will need reliable data and clear responsibility for it before moving to more advanced analysis. Each plan should set out who is responsible for delivery and how the results will be measured.

We ask digital supply partners to adopt the report's charter and demonstrate how their products meet it. Providers must be able to access their data through open, documented interfaces, exchange it safely with other systems and take it with them when they change supplier. Suppliers should develop products with people supported and staff, and show how their plans address the priorities in this report. Implementation, integration, support and exit costs should be clear from the outset.

Providers should use the charter and checklist in procurement and supplier reviews and budget for implementation. A proposed technical use-case library would provide more detailed guidance.

Staff need time and training to use technology safely and effectively. Experience across DEC providers points to poor system design, unclear purpose and lack of training time as greater barriers than age. Leaders need to understand digital and take responsibility for using it to improve the quality of services.

Technology can also support flexible working and new roles, including care technologists. [34] Staff should help shape the systems they use and challenge dehumanising language. Providers must take concerns about intrusive monitoring through rostering systems, sensors and AI seriously, with safeguards that protect privacy and maintain trust at work.

Engagement

The Digital Excellence in Care (DEC) group developed this work with Care England, Digital Care Hub, VODG, providers, digital supply partners and public bodies. Learning Disability England gathered views from people supported and families. Their involvement must continue as systems are developed and tested. Providers should share learning and practical examples so smaller organisations can build on work already done.

Government needs to provide national direction and make the case for funding, recognising that one organisation may pay for improvements that benefit another. NHS partners should include social care in shared records and neighbourhood services. Commissioners need to fund digital capability as part of care delivery. Regulators should agree how they can use evidence providers already hold, and workforce bodies should support the training staff and leaders need.

Standardisation

Providers must adopt common data definitions and reusable integrations to help reduce costs. They also need to accept common ways of working where local variation adds no value. Bespoke requirements should address a specific service need. Otherwise, providers and suppliers repeatedly pay to solve the same problems in different ways.

Suppliers should build to recognised standards, and commissioners should agree common reporting requirements, definitions and thresholds where local variation is unnecessary. Shared standards need to support personalised care and preserve providers' choice of systems.

The digital challenge

Problem statement

The cost of care is a growing financial challenge for the sector, with costs increasing at pace.

As set out in the Executive Summary, digital capability must be treated as part of the sector's core infrastructure rather than as a discretionary addition, given the scale of financial and demand pressure the sector is already under. [5] [6] [7]

Unlike the NHS, no single care organisation is big enough to invest in a single dominant solution, so fragmented models and standards are being delivered.

Government has set an ambition for adult social care to be fully digitised. For operational measurement, this means use of an assured digital social care record and meeting Data Security and Protection Toolkit standards. As the Executive Summary sets out, most providers already meet this foundation; the roadmap argues that digital excellence must go further: systems should connect, data should be usable and digital capability should enable better outcomes and different models of care rather than simply replacing paper. [8]

The current model of commissioning is not compatible with delivering personalised and digitised outcomes at scale. Commissioners and care providers need to work together to develop a new model of commissioning that reflects the model of digital care and how this translates into commissioning practice. Without system-led change at this level, digital care won't work and will continue to be seen as an additional cost burden.

Early implementations of digital care have been driven primarily by commissioners and many have not got past the pilot stage. This is due to several recurring factors:

- Point-based solutions — with very little investment or exploration into data extraction, insights or trend analysis.
- Universal solutions — solutions implemented across a whole cohort rather than person-led.
- Cost-saving focus — solutions focused on cost savings, rather than on utilising technology to improve outcomes. With commissioner-led solutions, larger care providers that deliver support across multiple authority areas end up supporting a fragmented digital estate, which makes developing and governing a cohesive data model very difficult.

The scale of investment required to fully digitise the sector is beyond any single care organisation to bear. Government needs to recognise the value of investing in fully digitising social care, working with commissioners to invest alongside care providers, in order to unlock savings and re-invest into new models of care.

Care and support has, in many respects, not fundamentally changed for decades. While expectations of people, advances in healthcare, and technological capability have moved forward at pace, the underlying model of care delivery remains largely rooted in historical approaches. Too often, technology is introduced and then forced to fit around this traditional model, resulting in fragmented, inefficient, and underutilised solutions. The opportunity now is to reverse that thinking. Rather than bending technology to fit outdated models, we must adapt and modernise the model of care itself to fully realise what technology can deliver. International examples suggest that where this shift has been embraced, care has become more preventative, more personalised, and more sustainable. Without this change, digital care will continue to be seen as an add-on cost rather than a core enabler of better care.

If we fail to work collaboratively on a shared digital care framework, people supported face significant risks to both efficiency and effectiveness across the system. Fragmented approaches can lead to duplicated effort, incompatible systems, inconsistent data standards and poor information sharing, increasing administrative burden and cost while reducing the ability to plan, commission and deliver joined-up services.

For practitioners, this can mean incomplete or delayed access to critical information, undermining decision-making, safeguarding and continuity of care. For individuals and carers, it can result in repeated assessments, gaps in support, and a poorer overall experience.

Strategically, a lack of collaboration weakens the sector's ability to leverage collective buying power, innovate at scale, meet national interoperability and assurance expectations and respond to escalating demand, ultimately reducing value for money and limiting the capacity of local authorities, ICBs and the independent sector to deliver timely, effective, and sustainable care and support.

In summary

- Sector fragmentation: multiple commissioners, care providers and digital supply partners, without central oversight, agreed standards, or visible central leadership.
 - Financial pressure: rising costs, local authority budgets under increasing pressure and a lack of economies of scale, unlike the NHS, despite social care being a similarly large sector.
 - Outdated commissioning models based on how many and how much, instead of how good, how personalised and improved quality of life.
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Context

Core principles

DEC's work is underpinned by six core principles for digital excellence in care:

- People first — technology serves people, not the other way around.
- Interoperability by default — systems and data must work together within, and across, organisations and sectors, abiding by data standards.
- Safety, privacy, and ethics — non-negotiable foundations.
- Co-production — designed with people who use and deliver care.
- Data protection — designed to enable communication, not prevent collaboration.
- Outcomes over outputs — what changes in someone's life matters most.

The legislative and policy context

The Care Act is digitally neutral in law, but digitally dependent in delivery. While there are no explicit statutory requirements mandating digital adoption within social care, the existing legislative and policy framework strongly supports it. The Care Act places duties on prevention, information and advice, safeguarding, and integration, all of which are significantly strengthened through effective use of data and

digital tools. [39] Similarly, the NHS's long-term ambitions around integrated care, shared records, and population health management rely on the ability of social care to participate as an equal, digitally enabled partner. Digital care is therefore not separate from these agendas; it is fundamental to delivering them. By aligning digital development in social care with these existing priorities, the sector can directly support national objectives while improving outcomes locally.

Data, technology and interoperability

Data is the information held about people, services, workforce, quality, finance and outcomes, together with the insight created when that information is analysed. Technology is the collection of systems, devices and infrastructure used to capture, process, present and act on that data. Interoperability is the ability of those systems and organisations to exchange and use information safely and meaningfully. It depends not only on technical connections, but also on consent, common definitions, information governance, data quality and staff confidence. [14] [16]

A new application can improve one task and still add to fragmentation. Equally, a provider can hold a large amount of data without being able to turn it into timely insight. Digital excellence requires data and technology to work together: technology that is usable and adaptable, data that is trustworthy and accessible to authorised users, and clear human accountability for the decisions that follow.

This report does not set out to audit which specific systems are interoperable with which today, for example, mapping the current state of medication management platforms or rostering tools system by system. That exercise would date quickly and vary by provider. Instead, the report sets out a blueprint: the interoperability requirements a digitally excellent sector needs, described by function rather than by product. Many of these integrations already exist in parts of the sector; others represent gaps. Closing those gaps is the work of subsequent workstreams, carried out in partnership with technology companies and sector stakeholders, and informed by the requirements set out here.

We have not costed individual technical integrations as part of this work, and readers should not expect a like-for-like cost comparison between systems in this report. What we can say is that the current landscape of largely custom, point-to-point integrations is itself a cost driver, one this report's push toward standardised, functionally-defined integration requirements is intended to help reduce over time. Interoperability will still carry a monetary cost. Understanding and realising the benefits it unlocks, for people, staff and organisations, is what will determine whether that cost is worth bearing, and that assessment is a necessary next step, not a gap in this report.

What digital care means for the sector

DEC proposes that digital care can create a number of key shifts:

- From time-and-task commissioning to outcomes-based commissioning.
- From rigid goals to agile, people-led outcomes.
- From command and control to an empowered workforce. Digital care can support a sector that is better cost-controlled, evidence-led, person-led and resilient:
- Less focus on time and task alone and greater visibility and transparency of what actually improves people's lives and a shared, real-time narrative of impact rather than quarterly reviews; contracts that are adjustable and tailored.

- Joined-up care and support using secure data sharing across care, health, housing and community services, leading to reduced fragmentation between localities, commissioners, and providers and consistency without uniformity, and ensuring people have access to and control over their own data.
 - Smarter commissioning with better use of data to understand demand and procurement that rewards quality.
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Vision for the future

We envision a future where technology supports people to live lives shaped by their own choices, goals and aspirations.

People are supported to clearly express what matters to them, what their good life looks like, and the outcomes they want to achieve, such as greater independence, stronger relationships, better health, or meaningful activity. People can feed back on their experiences of what helps them achieve their goals, and raise any concerns. Digital tools make this communication accessible, easy to understand, and owned by the person, helping to build confidence, capability and control in everyday life.

Technology works quietly in the background to support independence and monitor safety without reducing human connection. It helps people manage their day: choosing their care needs for the week ahead, managing their routines, supporting their resilience, and accessing virtual support whenever they need it, feeling empowered and respected. Technology reduces the anxiety of people supported by making support more dynamic, responsive and tailored to needs, enabling independence to grow safely, not at the expense of wellbeing.

For caregivers, information is at their fingertips, freeing them to focus on human interaction. Information is completed automatically where possible, so their role can focus on true care, support and better outcomes. Every day, caregivers can feed back on how they are feeling and what kind of day they have had, raising any concerns or flagging any issues.

For providers, technology shifts care from reactive to personalised, from generic to tailored, from one-size-fits-all to best-value. Joined-up information and early flagging help staff notice small changes that may indicate emerging risks, safeguarding concerns, or declining health. This allows teams to act earlier, have better conversations, and intervene before issues escalate into crises or hospital admissions. Professional judgement remains central, but is strengthened by clearer information, shared understanding and timely prompts.

We envision a digitally empowered workforce, where pay and additional shifts are managed in the moment, through simple, accessible and automated interfaces, and where the workforce is trained to identify early warnings for hospital admissions or changes in care needs, with real-time communication with social workers and the healthcare sector as the norm.

At a system level, this future state creates confidence, quality and trust. Providers can demonstrate outcomes, safety and impact; reduce duplication and administrative burden; and focus time where it matters most, with people. Safeguarding is strengthened through early recognition rather than late response, staff are better supported, and care becomes more sustainable. Technology, used responsibly, helps everyone make better decisions together, enabling people to thrive in lives that are truly their own.

Showing how the model could work

John does not want support to begin at 7am every morning. He can make his own breakfast and would rather use his funded support later in the day so he can go out and attend an evening gig. Through an accessible interface, John records the change he wants. The system checks his consent and the agreed boundaries of his support plan, alerts the responsible manager where approval is needed, and updates the rota and care record once agreed, ensuring that staff have sufficient notice and that their working pattern complies with employment law and good practice. Relevant staff see the revised plan; John can see that his request has been actioned; and, where he has chosen this, his family or commissioner can see the appropriate outcome information. The organisation can then compare what John said he wanted with what was actually delivered and whether it supported the outcome he chose.

The hours provided will be automatically transferred from the roster system to the finance system for invoicing and reconciliation with the local authority, and payment is prompt.

Implications for people supported and the workforce

People supported

Technology's central purpose in this vision is to widen choice and control for people supported, not to add complexity to their lives. The Key requirements chapter, particularly the Families and People we support sections, sets out in detail what this looks like in practice: information delivered in accessible formats, multimedia used to evidence achievement rather than as an incidental by-product, and a clear, continuous line of sight between what a person wants from their life and the support they actually receive day to day.

This chapter does not repeat that detail. Instead, it draws out the two things that flow directly from it for people supported: first, that accessibility and choice only work if they are built in by default, not retrofitted; and second, that the technology must never be allowed to speak for the person; it should amplify their voice, not replace it. If we get this right, it will empower people.

Feedback from people supported and their families has been consistent: keep it simple. Information and tools should use everyday language, not jargon, and should encourage creativity, including the use of photos and videos, rather than reducing someone's life to text on a page.

Workforce

Technology creates both a challenge and an opportunity for the sector.

When considering digital transformation and data sharing, organisations should consider both the technical implementation – rolling the technology out and embedding it – as well as the overall transformation of processes and care delivery and the role teams have within that. Digital can only be the enabler, people are what make the change.

The adult social care workforce has an older age profile than many other sectors. According to Skills for Care, the average age of the workforce is 45 years old, with almost a third of colleagues aged 55 or over and likely to retire within the next decade. [32] There is a persistent myth that older colleagues resist technology. The evidence from across DEC's provider membership does not support this: resistance, where it exists, is driven far more by poorly designed systems, unclear purpose, or lack of training time, than by age.

At the same time, a new and increasingly tech savvy generation of workers expects digital tools, mobile technology and flexible ways of working to be a normal part of working life. A lot of people across the workforce, not just newer entrants, are already tech savvy. Technology may create a more compelling career opportunity for some younger people, with new roles such as care technologists and digital care workers becoming more established.

The care workforce of the next decade will need to feel as comfortable using digital tools, data and technology as it does using traditional care skills. This does not mean every colleague becomes a technologist, rather that they are confident in using technology safely, ethically and effectively to improve the lives of people supported, regardless of when they started their career.

The key facets of a successful implementation from a workforce perspective should include:

1. Requirements gathering and co-design

Engage teams from the outset, rather than leading with the technology.

Digital transformation programmes should involve teams every step of the way and should not be led by the technology itself. Consideration should be given to the outcomes the provider is looking to achieve, then engage the workforce to identify where current systems and processes are falling short. Winning hearts and minds at this early stage lays the foundation for good adoption later in the programme.

Concerns remain about the ‘big brother’ potential of rostering systems, sensors and AI technologies installed into people’s homes and workplaces: the risk that granular, continuous oversight of where staff are, how long a task took, or what a sensor recorded, tips over into surveillance of colleagues’ actions and working lives, rather than support for the people being cared for. Strong ethics frameworks must be embedded in organisations to ensure these concerns are understood and acted on directly, balancing legitimate operational visibility with colleagues’ reasonable expectation of trust and privacy at work.

2. Digital readiness and training

Use a digital literacy survey to match training to where staff currently are, with protected time to learn.

The use of a digital readiness or digital literacy survey can help ensure that staff are getting the right types of training and support, matched to where they currently are rather than assumed. The Digitising Social Care team have published a tool that could be used as a starting point for measuring digital literacy:

<https://beta.digitisingsocialcare.co.uk/digital-skills-self-assessment-tool-adult-social-care>

Realising a digitally confident workforce requires a genuine and deliberate training commitment. Staff churn in a care organisation is some of the highest in any sector, so ensuring provision for ongoing training and protected learning time is essential to sustained adoption. There also needs to be a greater emphasis for organisational leaders specifically on understanding digital and using it to leverage better quality of services, rather than treating it as an operational matter to delegate downward.

3. Feedback opportunities

Give staff a voice on process and tools; helps leadership see where change has the greatest impact.

Understanding staff requirements and demonstrating leadership-level commitment to ethical technology deployment will lay the foundation for successful digital transformation amongst the workforce.

The golden thread of high adoption within technology programmes is workforce readiness and acceptance of change, but giving opportunities to provide feedback on processes and tools will ensure staff feel listened to and will give leadership the chance to understand where changes might have the greatest impact.

Moving from a technical implementation to full transformation

Successful deployment is only the first milestone. Once a system is live and staff are competently using it, the work shifts from technical implementation to full transformation, moving beyond “does the technology work” to “has it changed how we deliver care.” That shift depends entirely on the workforce.

A key part of technology deployment in care is ensuring that teams are enabled to use technology in a way that remains person centred, and, where possible, improves the language and approaches being used.

Technology has the ability to shine a light on less than ideal practices and language, and staff need to be trained and supported to spot that and make improvements. Left unaddressed, a new system simply digitises existing habits, good or bad. Used well, it becomes a prompt for reflection.

The workforce should also be empowered to use technology to offer more person centred approaches to care. AI tools and modern software can highlight where there are gaps, for example in care plans or in the language used to document ongoing care, but they cannot and should not be responsible for improvements to care itself. Making those improvements depends on staff having the right mindset and the confidence to act on what the tools surface.

Colleagues need the confidence to ensure technology does not force dehumanising language or actions, advocating plain language such as ‘going out’ instead of ‘accessing the community’, and language that promotes a person led ethos.

How this report supports Neighbourhood Health and the wider NHS digital ambition

The move towards neighbourhood-based health and more joined-up, digitally enabled services cannot be achieved with adult social care treated as an afterthought. People drawing on working-age adult social care often interact with multiple health, care, housing and community services. Care providers therefore hold an important longitudinal view of people’s lives, needs, outcomes and changing circumstances which should form part of the wider health and care information picture.

This report is social care’s practical contribution to that ambition. NHS England’s Neighbourhood Health guidance states that clinical systems should be compatible and integrated with general practice, digital social care records and other provider systems. Shared care records and the proposed Single Patient Record create a wider route for relevant information to be available around the person. Used with appropriate consent and governance, this can reduce repeated assessments, support earlier intervention, improve multidisciplinary decision-making and make transitions between health and social care safer and more effective. [10] [11] [12] [13]

Delivering this will also require commissioning and investment models to recognise digital capability as part of modern care delivery rather than an optional additional cost. The organisation making the investment will not always be the organisation receiving the financial benefit: investment by a care provider may reduce escalation, duplication or demand elsewhere in the system. Providers, commissioners and NHS partners therefore need shared outcomes and investment approaches which allow the benefits and costs of digital transformation to be considered across organisational boundaries.

Wider sector initiatives

Whilst this report focuses on data sharing and technology within the care provider organisation, it recognises that this all sits within a wider context of sector digitalisation.

In 2022 the Department of Health and Social Care, along with NHS England, launched over £150m of funding for the adult social care sector. The aim was to move care providers away from paper systems and onto assured digital social care records (DSCRs). [40] Today, the large majority of CQC-registered providers use a DSCR (estimated at around 83.6%). [41] However, this measure focuses solely on care records and overlooks the broader digital estate that exists within a care provider organisation.

Further sector initiatives are underway, however, which could have a significant and positive impact on both care provider organisations and the people they support. In the context of this report, providers

should consider how they can future-proof their digital buying decisions. The systems procured today will shape how data can be collected, shared and used in the future.

Social Care Interoperability Platform (SCIP)

The 10 Year Health Plan for England: Fit for the Future, published in July 2025, set out ambitions for further digitalisation of adult social care. It envisages data being shared across care services as well as with the NHS. Work has already been completed to align assured DSCR platforms to a common set of Minimum Operational Data Standards (MODS).

The next step is SCIP: national infrastructure that moves standardised data between systems, so that providers and suppliers no longer need to build and maintain individual connections. [45] Initial use cases include access to care information for assessment and planning, safeguarding and safety alerts, and the transfer of records between care providers. A first-stage minimum viable product was commissioned for delivery by March 2026. As of August 2026, supplier hackathons have been hosted but no further integration work has been undertaken.

This work is underpinned by the Data (Use and Access) Act 2025. [42] The Act extends mandatory information standards to the IT suppliers of health and adult social care systems, covering functionality, interoperability, portability, storage and access, and security. The Secretary of State can require suppliers to evidence compliance and can publicly censure those that fail to comply. The Act also enables a supporting IT accreditation scheme.

Care providers already have a separate statutory duty, under the Health and Care Act 2022, to comply with the information standards that apply to them. [39] Technology that cannot meet these standards may therefore leave providers unable to meet their own obligations.

Get Adult Social Care Data (GASCD)

GASCD is a free digital service from DHSC, launched in 2026 for CQC-registered providers. [43] It was designed to help the sector better understand data trends and support evidence-based decision making. Early access opened in January 2026, and all nominated individuals and registered managers were invited to register from June 2026. Using nationally published datasets, GASCD is a read-only dashboard surfacing:

- Local area breakdowns of community care services by type
- Bed occupancy compared with local averages for care homes
- What community and residential services are in demand from the local authority
- How the local authority breaks down its social care funding
- Disability prevalence by area

This type of benchmarking data can strengthen business cases for expanding capacity or reshaping a service mix. It can also improve the evidence base in conversations with local authority and ICB partners.

NHS Digital Medicines Programme

NHS England's Digital Medicines Programme aims to create a single, connected medicines pathway, so that accurate, up-to-date medicines information follows the person wherever their care is delivered. [44] The programme's published focus is on primary care, hospitals and community pharmacy but engagement has now begun with eMAR systems and DSCRs. From a social care perspective, the programme is currently assessing the eMAR market and digital prescribing infrastructure, with a particular focus on proxy ordering and pharmacy integration. Over time, this could bring new data standards and simpler routes for eMAR systems to integrate directly with GP and pharmacy systems. Providers should ask their eMAR and pharmacy suppliers how they are engaging with this programme, to make sure systems are fit for future compliance and data sharing.

Key requirements

How the eight domains work together

The eight domains describe the main information relationships that need to work together in a digitally excellent provider. People we support and Families describe the person-facing experience. Finance, People, Estates and Quality & improvement describe the core organisational functions that plan, deliver and assure support. Commissioning and Regulatory assurance describe the external accountability relationships explicitly represented in the model. They are presented separately so providers can navigate the detail, but they should not be implemented as eight independent projects.

Quality & improvement and Regulatory assurance are deliberately separate. Quality & improvement is the provider's internal cycle of assurance, learning, action and sustained improvement. Regulatory assurance is the proportionate use of relevant provider-held evidence with CQC and, where applicable, Ofsted. The same trusted source data should support both without requiring parallel records or duplicate reporting. The value comes from the connections between them. A change in a person's needs may affect the care record, staffing, rota, funding, risk assessment and commissioner evidence. A workforce issue may be visible in recruitment, sickness, agency use, quality and finance. Digital excellence means that authorised information can move across those boundaries with common definitions, clear governance and as little re-entry as possible. The diagrams in each domain show the difference between a fragmented current state and a more connected future state; the narrative explains why that change should matter.

Practical tools within the roadmap

This report is designed to be used, not simply read. The domain navigation table provides a quick route to the relevant area. The requirement summaries provide a common starting point for internal planning and procurement. The current/future-state diagrams help teams identify where data is duplicated or blocked. The Data Maturity Model helps providers consider their position by domain. The digital supply partner charter and checklist provide a consistent basis for discussions with technology organisations. Together, these tools support a provider to move from identifying a problem to testing a practical route towards digital excellence.

User guide and caveats for requirement summaries

Scope of the requirement summaries

The requirements set out in this report reflect priority requirements identified for each of the data user groups this work focused on. They are not intended to represent every provider's priorities: different organisations will have different priorities and there will be legitimate variation in system set-up and individual process design across the sector. These summaries are a starting point for thinking, not a universal specification.

How to use these summaries

Each summary is designed to help providers think through the shape of their own digital estate and to support conversations with procurement teams and digital supply partners. The broader aim of this report is to work toward a future state for care technology interoperability, but that future state has to be built incrementally to have real impact, which is why this work deliberately started with the top three

requirements per data user, rather than attempting to cover everything at once.

A note on the People we support and Families sections

The People we support and Families sections are formatted differently from the other six groups in this chapter. For those two groups, a per-requirement Current State / Future State interoperability breakdown doesn't apply in the same way it does elsewhere; instead, each group has a single shared diagram covering what the workshop termed "access requirements"; how information, consent, and delivery channels work together across all three of that group's requirements at once. That single access requirements summary appears once at the start of each of those two sections, rather than being repeated per requirement.

A recurring pattern: dashboards and the case for aggregation

Readers will notice that dashboards appear repeatedly across almost every requirement in this report. Working toward a genuine future state of interoperability means resolving how that aggregation actually happens, and in practice this comes down to one of two models:

- **Accountable core digital supply partner:** a single system already in the provider's estate (this might be the digital social care record, the rostering system, the contracts system, or another core system depending on the requirement) becomes the designated aggregator, surfacing data from other systems as a dashboard or single pane of glass. This model particularly benefits smaller providers who may not have the resource for the alternative below. Its main limitation is a lack of personalisation, providers often have nuanced data and reporting needs that a single digital supply partner's dashboard may not fully accommodate.
- **Dedicated in-house data and reporting resource:** no such role exists as standard in the care sector today, though a number of providers already run their own data and insight teams. This becomes a critical function if a provider chooses to build digital supply partner-agnostic dashboards of its own. The benefit is future-proofing the digital estate and reducing reliance on any single digital supply partner's roadmap; the cost is the additional investment and infrastructure required, in a sector that already faces real recruitment and retention pressure.

The commissioner standardisation barrier

Across interviews and stakeholder events, one blocker to a future state for interoperability came up consistently: the lack of consistency in commissioner systems and reporting requirements. This report recommends that, particularly in the areas of compliance and risk, local authority thresholds be standardised across England. Providers could save significant time each month, and materially improve the efficiency and effectiveness of their reporting, if this were addressed. The variation seen today across different commissioners makes it effectively impossible for providers and digital supply partners to build toward a single, aligned standard.

What follows this report

We are proposing to develop a data use library and a practical roadmap which gives providers detailed guidance on how to implement the recommendations in this report. We will also be producing an accessible version of this report as we want the people we support to understand the improvements we want to make in digital social care. We will also be monitoring the impact that this report has and will involve people we support and families in that process. A more detailed implementation framework and supporting roadmap will follow as the next phase of work.

Key requirements — navigation

This table lists the priority requirements identified for each of the eight data user-groups covered in this chapter, with the page each section starts on. Each group below is its own self-contained section, starting on a fresh page, use this table to go straight to the section that's relevant to you rather than reading the chapter end to end.

DATA USER-GROUP	PAGE	#1	#2	#3	#4
People we support	p.20	Digital information should be as accessible as possible	Digital systems enable creativity through the use of multi-media	I get the support I need to live my good life	
Families	p.24	Information is used to promote inclusion and improve quality of life	We have access to and can share important information about our loved one, as long as there is appropriate consent	Digital systems should be easy for family members to use	
Finance	p.28	Reconciliation of commissioned vs delivered vs billed hours	Uplift modelling for contract negotiations	Forecasting revenue based on referrals pipeline & capacity	
Commissioning: local authorities and ICBs	p.33	Contract monitoring & KPI compliance	Safeguarding, reporting & information sharing	Market intelligence & risk monitoring	
People	p.39	Recruitment pipeline & vacancy management	DBS & compliance tracking	Visa sponsorship + international recruitment	
Regulatory assurance	p.44	Medication safety & MAR documentation	Care planning & risk assessment quality	Early warning system to identify services at risk of a poor culture and potential abuse	
Estates	p.49	Planned preventative maintenance and compliance	Reactive maintenance triage	Safety systems integration	
Quality & improvement	p.54	Quality governance, assurance & improvement	Cyber security, resilience & information governance	Staffing level compliance & safe staffing checks	Real-time risk & incident monitoring

People we support

Why this domain is important

Digital information is only useful to the person if they can understand it, contribute to it and see that it changes what happens. In the current state, communication needs may be recorded in one plan but applied manually and inconsistently elsewhere; photos and videos may sit outside the care record and daily notes may show completed tasks without showing whether the person is living the life they chose.

The future state uses the person's communication plan across systems, records multimedia with consent as evidence of experience and achievement and links the person's goals to what rotas, activities and daily records show is actually being delivered. This does not allow technology to speak for the person; it gives the person more ways to express preferences and gives the organisation a clearer line of sight between stated outcomes and everyday support.

Learning Disability England's consultation with 45 people and family members reinforced the need for easy-read and other accessible formats, simple systems, creative use of photos, video and voice and information that improves quality of life rather than becoming a tick-box exercise. [35] The value is increased choice and control, better evidence of outcomes and earlier visibility when delivery is drifting away from what matters to the person.

How to read the current and future state

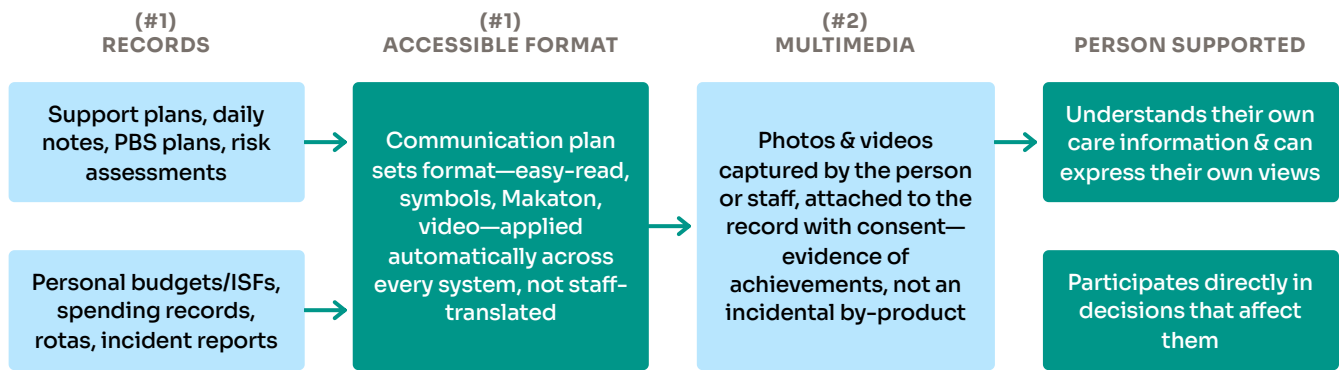
The current-state diagram shows accessibility, multimedia and delivery information separated. The future state connects those elements around one person-led record. The expected improvement follows from applying the person's communication needs consistently and comparing intended outcomes with actual delivery.

All three requirements for people supported draw on the same underlying record. Information is only meaningful to the person if it reaches them in a format they understand; multimedia turns daily activity into real evidence of their life rather than a by-product and neither matters if the support behind them doesn't actually deliver against what the person said they wanted. These are three lenses on one person-led record, not three separate systems.

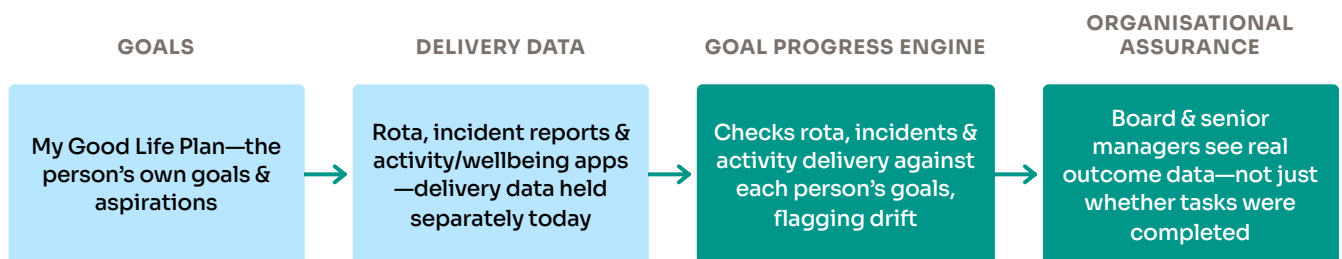
Access requirements

Communication needs are captured once, in the person's own communication plan, and applied automatically across every system the person interacts with, whether easy-read, symbols, Makaton, or video, rather than being translated by staff each time. Photos and videos are captured with consent and attached to the record as evidence of the person's achievements, not treated as an incidental by-product of daily activity. The person's own goals and aspirations, recorded in their "My Good Life Plan" or equivalent, are checked against what rotas, incident reports and activity records show is actually happening day to day, so that drift between what someone wants and what they're receiving is visible to the organisation, not just to the person themselves. [36] There should be a smooth handover of information about a person's needs and preferences if their support provider changes.

How the person accesses information and expresses themselves (#1 + #2)



Whether that support is actually working (#3)



Note: All three requirements draw on the same underlying record. Information is only meaningful to the person if it reaches them in a format they understand (#1); multimedia turns daily activity into real evidence of their life rather than a by-product (#2); and neither matters if the support behind them doesn't actually deliver against what the person said they wanted (#3). These are three lenses on one person-centred record, not three separate systems.

#1 — Digital information should be as accessible as possible

Definition

The requirement that all digital information and systems the person receiving support interacts with are presented and delivered in a way that matches their individual communication needs, cognitive ability, sensory needs, and preferences. The aim is that the person supported can understand information about their own care, express their own views, and participate in decisions affecting them, rather than accessibility being mediated en rely through staff or family.

Inputs

- Support plans, daily notes, activity plans, positive behaviour support plans, risk assessments, personal budgets or individual service funds, spending records, communication plans, rotas and incident reports
- Digital social care records, activity and wellbeing apps, and financial tools

Expected outcomes and measures of success

- **Organisational:** Evidence from audits and feedback from families and people supported demonstrates that information is accessible and easy to understand. People's communication plans show how they prefer to be communicated with (e.g. via Makaton), and that is reflected in all information held about them.
- **Strategic:** The organisation can demonstrate that people supported have access to information about themselves that they are able to understand, and that they have maximum choice and control over their lives.

#2 — Digital systems enable creativity through the use of multimedia

Definition

The ability to capture, store, and share photos, videos, and other multimedia created during the course of someone's care and support, so that it can be used to communicate meaningfully with the person supported and their family, reflect their preferred communication style, and evidence the outcomes and experiences that matter to them. This turns multimedia from an incidental by-product of daily activity into a purposeful tool: recording achievements, celebrating choice and control, and giving people supported a richer way to express and understand their own lives than text-based notes alone.

Inputs

- Digital social care records
- Photos and videos from the person's device and photos/videos shared with family members

Expected outcomes and measures of success

- **Organisational:** People supported and their staff teams routinely use multimedia to help share information with the person being supported and their family. There is evidence from audits and feedback that their preferred style of communication, as reflected in their communication plan, is being used in practice.
- **Strategic:** The use of multimedia builds a strong person-led culture that focuses on celebrating people achieving their desired outcomes and having as much choice and control over their lives as possible.

#3 — I get the support I need to live my good life

Definition

The requirement that digital systems enable a clear, continuous line of sight between what a person wants from their life and the actual support they receive day to day. This shifts the focus from simply recording that tasks were completed, to evidencing whether the person is genuinely progressing toward the life they want, and whether staffing and rostering are consistently delivering the support needed to make that possible.

Inputs

- Care documentation: support plans and other care documents
- Goals and aspirations: the "My Good Life Plan" or equivalent
- Workforce and delivery data: staff rota, incident and activity platforms

Expected outcomes and measures of success

- **Organisational:** Audits, together with feedback from people supported and families, demonstrate that people are achieving their goals and aspirations, and that rotas show people are receiving their funded level of support.
 - **Strategic:** There is a strong organisational culture which celebrates people achieving their hopes and dreams. The Board and senior managers receive regular data showing outcomes that people supported are achieving.
-

Families

Why this domain is important

The problem is not simply that families receive too few digital updates. Information may sit in several systems, consent may be recorded inconsistently and the available portal may not work for the family member who is expected to use it. The future state is a controlled two-way relationship: the person's consent and legal authority determine access, relevant information is drawn from the accountable care record and family contributions are reviewed before they become part of that record.

Improvement is created through visibility, timeliness and participation. Families can understand what is happening without relying entirely on calls and emails, while staff can use knowledge held by families to support continuity and person-led decisions. Care England research found that, among families whose provider offered a digital platform, 81% said it contributed positively to the quality of care, 62% wanted updates through an app or portal compared with 41% receiving them and 87% of platform users said they could share information back. The same research identified usability, training, privacy and timeliness as conditions for success. [1]

A second survey found that 97% of respondents experienced difficulty when arranging care and that only 19% used inspection reports while researching providers. This supports the case for accessible, meaningful information rather than more data presented in professional formats. [2] The return on investment is therefore broader than reduced administration; it includes confidence, stronger partnership, fewer avoidable communication gaps and better use of family knowledge.

How to read the current and future state

The current-state diagram shows consent, content and communication channels held separately. The future-state diagram shows one accountable record, consent applied consistently and information delivered through an accessible channel. The benefit comes from the controlled connection between those elements, not from the portal alone.

The three requirements for families form one chain, not three separate problems: content only reaches a family member once it has passed through the consent and capacity gate, which determines what that specific contact is allowed to see or contribute, and it only becomes usable in practice if the delivery channel itself is accessible to that family member. A technically correct permission is meaningless if the app it's delivered through doesn't work on their device or is too complex for them to use; inclusion, consent, and usability succeed or fail together.

Access requirements

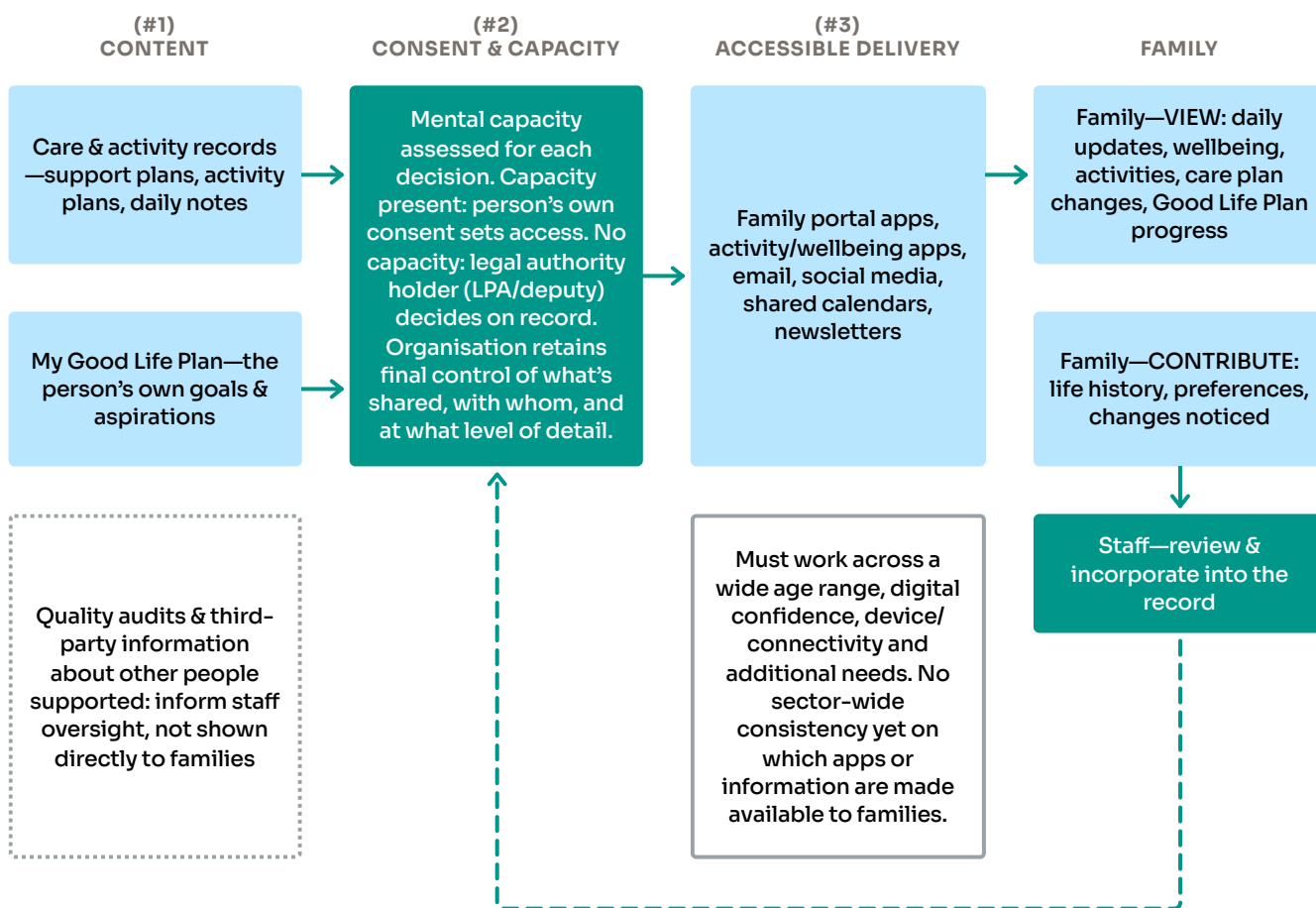
Mental capacity is assessed for each decision. Where capacity is present, the person's own consent sets access; where capacity is absent, the legal authority holder (the holder of Lasting Power of Attorney, or a court-appointed deputy) decides. The organisation retains final control of what is shared, with whom and at what level of detail. Access reflects the person's own choice, not a default next-of-kin setting. Family submissions are reviewed by staff before being incorporated, preserving one accountable version of the record.

Providers should see family members as partners in ensuring the delivery of person-centred care and support. Where people lack capacity, providers should actively involve family members through a best interest process. Not all family members have legal powers, such as the power of attorney or deputyship, but know their loved one better than anyone else and have an important role to play. The implementation

of digital technology should promote best practice in using the Mental Capacity Act and involving families.

How the model works

A 28-year-old man with a learning disability and autism lives in supported living. His mother is very involved and staff often turn to her to interpret his wishes. He communicates confidently using pictures when settled, but during sensory overload may stop speaking and agree to questions simply to end the conversation. Together, they create a digital communication passport showing how he expresses choice, uncertainty and distress, alongside his preferences about what his mother can see through the family portal. Before decisions, a tablet presents one choice at a time using familiar photographs, with options for “not now” and “help me understand”. Staff record the support offered and the conditions in which he responds. Over time, this reveals that several episodes described as fluctuating capacity followed noisy appointments or repeated questioning; revisiting the decision in a quiet space often enables him to express a clear choice. His mother can contribute valuable observations through the portal, but these remain distinguishable from his own response.



Note: The three requirements form one chain, not three separate problems: content (#1) only reaches a family member once it has passed through the consent and capacity gate (#2), which determines what that specific contact is allowed to see or contribute — and it only becomes usable in practice if the delivery channel itself is accessible to that family member (#3). A technically correct permission is meaningless if the app it's delivered through doesn't work on their device or is too complex for them to use; inclusion, consent, and usability succeed or fail together.

Access reflects the person's own choice, not a default next-of-kin setting. Family submissions are reviewed by staff before being incorporated, preserving one accountable version of the record. Quality audit data and information about other people supported never routes to the family view. Email and social media are current-state channels only, not a controlled long-term mechanism; consent status itself is not yet unified across the systems that hold it.

#1 — Information is used to promote inclusion and improve quality of life

Definition

The ability for family members to access up-to-date information about the person, so they can stay involved in that person's life, understand what matters to them, and contribute to decisions that affect their wellbeing. This covers day-to-day updates (activities, wellbeing, health, care plan changes) as well as opportunities to share knowledge back into the care record (life history, preferences, changes noticed by the family).

Inputs

- Care and activity records: support plans, activity plans, daily notes
- Goals and aspirations: the "My Good Life Plan" or equivalent
- Quality assurance: relevant quality audits
- Delivery channels: digital social care record, family portal apps, activity and engagement apps

Expected outcomes and measures of success

- **Organisational:** The organisation is able to track outcomes for people supported and quality-of-life measures which show improvement over time. Audits and feedback from people supported and families demonstrate improvements in people's lives which reflect their goals and aspirations.
- **Strategic:** The organisation has a strong person-led ethos with a real focus on the lives of the people supported. The Board and senior leaders receive data which tells them how well people are achieving their goals, and aggregates information on significant outcome measures like health improvement and employment.

#2 — We have access to and can share important information about our loved one, as long as there is appropriate consent

Definition

The ability for family members to view relevant information held about the person they care about, and to contribute information back into the care record, within clearly defined and appropriately managed consent boundaries. The organisation retains full control over what is shared, with whom, and at what level of detail, based on the person's consent status and mental capacity. Where the person cannot give or manage their own consent, this extends to the person who holds legal authority to make those decisions on their behalf.

Inputs

- Care and activity records: support plans, activity plans, daily notes
- Family-facing channels: family portal apps, activity and engagement apps, email, social media, shared calendars

- **Consent:** captured across the digital social care record, contract management tools and dedicated e-consent tools

Expected outcomes and measures of success

- **Organisational:** Audits and feedback from families demonstrate appropriate access to information and a high level of satisfaction about information sharing. Data protection and consent issues are infrequent and less challenging to manage.
- **Strategic:** There is a strong culture of partnership between families and the care provider, where information is shared subject to the person's consent, and concerns are resolved quickly and transparently. Administrative burden via emails and calls received by families is reduced, freeing up time for the organisation.

#3 — Digital systems should be easy for family members to use

Definition

The expectation that any digital tools family members are asked to interact with are accessible and intuitive. This includes accounting for a wide age range and range of digital confidence across family members, varying devices and connectivity, and additional needs. Ease of use is what makes inclusion, and consented information sharing, work in practice.

Inputs

- Family portals, activity and wellbeing apps, email, social media, shared calendars, and newsletters

Expected outcomes and measures of success

- **Organisational:** Family feedback demonstrates that families find digital systems easy to use and are able to get support quickly and easily if they need it.
 - **Strategic:** There is a strong culture of partnership between families and the care provider. Families are comfortable accessing the provider's digital systems to share information.
-

Finance

Why this domain is important

Finance teams often reconcile commissioned support, delivered activity and invoicing across separate systems and spreadsheets. The work can identify errors only after the event, while referral, occupancy, workforce and contract information may be compiled manually for forecasts. This creates administrative effort, delayed billing and limited confidence in the organisation's financial position.

The future state connects contract, rostering, care-delivery and finance information so that routine reconciliation is automated and people investigate exceptions. It also brings referral, capacity, workforce and fee information into the same forecasting view. The technology does not decide what should be invoiced or what an uplift should be; it makes the evidence traceable and available at the point of decision.

Care England's Adult Social Care Insights report describes short staffing, complexity and financial strain as a persistent operating environment and identifies digital maturity as one of the factors providers can influence to improve visibility and control. [3] That evidence supports the direction of travel but does not quantify the savings from this specific finance model. The expected return is fewer missed or disputed invoices, less manual reconciliation, better cash-flow visibility, more credible fee negotiations and earlier warning when planned growth cannot be delivered safely.

How to read the current and future state

The current-state diagrams show contracts, rostering and finance being reconciled manually. The future state connects them through agreed data fields and exception reporting. The improvement comes from reducing re-entry and creating a traceable line from the commissioned package to delivery, invoice and payment.

#1 — Income recognition

Definition

Income recognition ensures that income is accurately recorded and validated against contractual terms, agreed activity levels, and evidence of service delivery, giving care leaders confidence that reported earnings reflect the true financial position of the organisation.

Inputs

- Commissioned hours from the contracts team
- Delivered hours via rostering and care monitoring systems
- Billed hours through finance systems

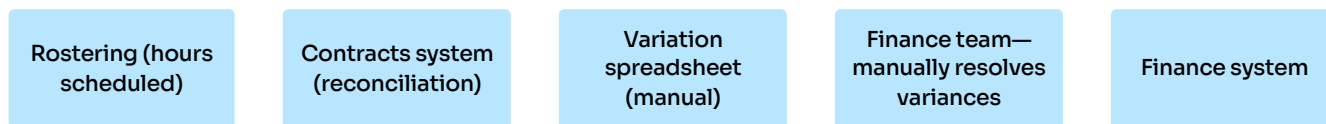
Expected outcomes and measures of success

- **Organisational:** Consistent and automated reconciliation across income streams
- Human input by exception, with clear reporting
- Reduced clawback exposure from local authorities
- Reduced time from purchase order to payment
- Fewer invoice queries, removing blockers to timely payment
- **Strategic:** Greater financial stability for providers

- Stronger, more trusted relationships with commissioners
- More time for finance teams to focus on higher-value activity

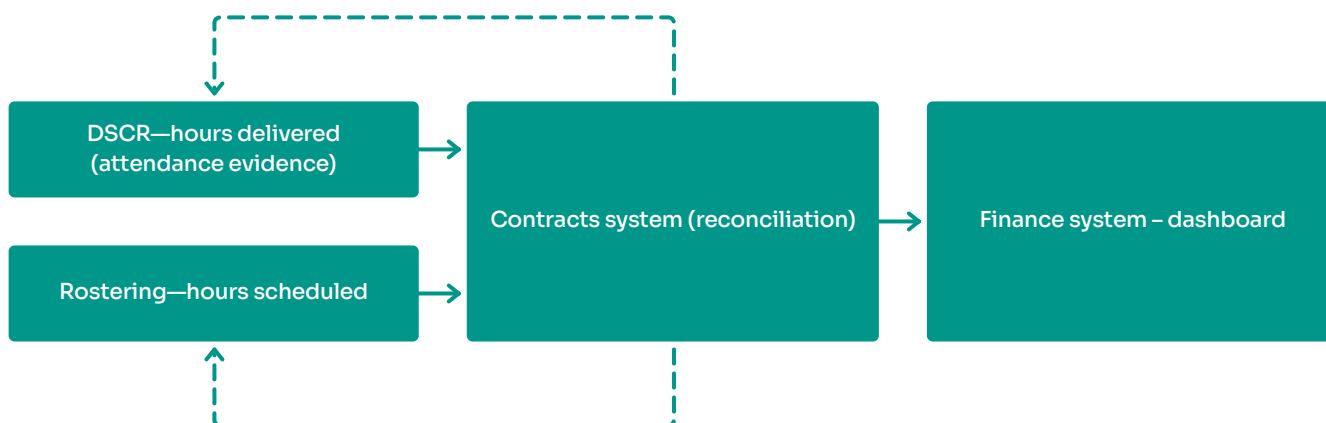
Interoperability

CURRENT STATE



Note: the contracts system's reconciliation output doesn't map cleanly to the finance system's format, so a finance team member manually translates and chases variances via spreadsheet before hours can be billed. Rostering shows who was scheduled, not confirmed delivery.

FUTURE STATE



Note: DSCR now supplies confirmed hours delivered, replacing rostering as the billing source of truth; rostering remains for scheduling comparison. Reconciliation alerts flag under/over-delivery back to DSCR—hours are not auto-billed without finance review.

#2 — Uplift modelling for contract negotiations

Definition

The ability to model and evidence the true cost of care delivery, including staffing, overheads, inflation, and regulatory/statutory cost pressures, to support robust, data-led negotiation of fee uplifts with local authorities and Integrated Care Boards. This also supports the organisation's own efficiency agenda, helping identify where cost pressures can be managed internally versus where they genuinely require a fee increase to remain sustainable.

Inputs

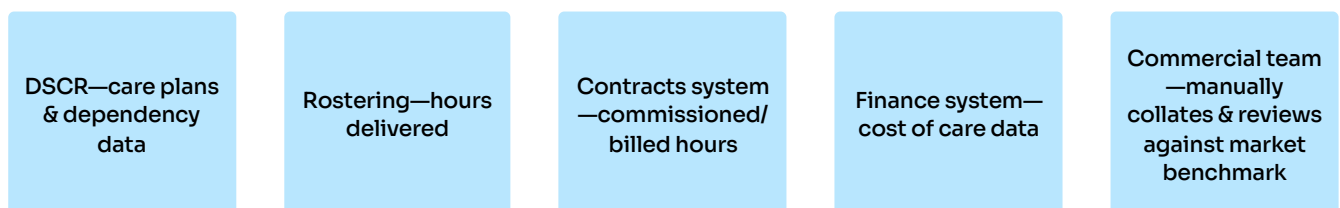
- Cost of care data by contract/service (staffing, overheads, non-pay costs)
- Commissioned/delivered/billed hours and rate data
- Inflation indices and statutory cost drivers (National Living Wage, National Insurance, pension contributions)
- Historic uplift requests and outcomes by commissioner
- Contract terms and review/negotiation dates
- Benchmarking data on cost of care
- Local authority/Integrated Care Board financial position and fee-setting policy data

Expected outcomes and measures of success

- **Organisational:** Time saving for organisations and commissioners through reduced negotiation time, with cost evidence readily available
- Consistency for staff teams and people receiving support, with sustainable funding reducing disruption
- Improved accuracy and rationale of uplift requests, reducing back-and-forth and repeated challenge from commissioners
- **Strategic:** Safe, sustainable, high-quality care underpinned by fee levels that genuinely reflect the cost of safe delivery
- Improving relationships with commissioners through transparent, evidence-based negotiation
- Greater market and provider sustainability, reducing the risk of service withdrawal caused by unsustainable fee levels

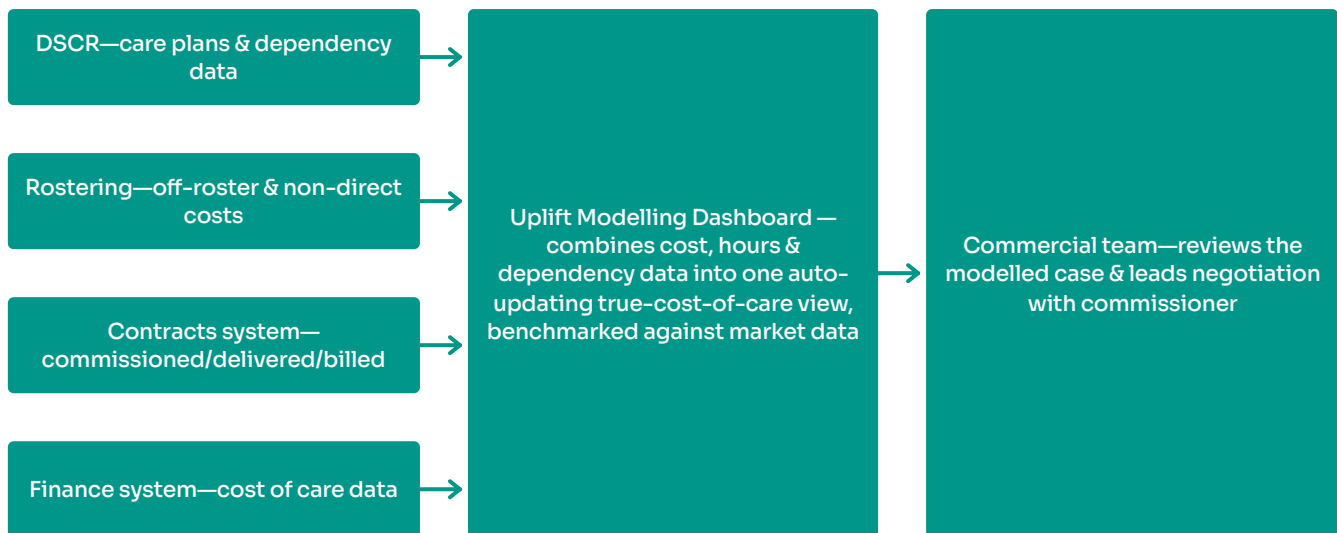
Interoperability

CURRENT STATE



Note: cost of care, hours and dependency data sit in four separate systems; a commercial team member manually collates and cross-checks them against market benchmarks before every negotiation—a process repeated for each commissioner and renewal.

FUTURE STATE



Note: the dashboard builds the evidence base automatically, including local authority/ICB financial position data from Market Intelligence & Risk Monitoring—the commercial team still leads the negotiation itself. This closes the data-collation gap, not the negotiation judgement.

#3 — Forecasting revenue based on referrals pipeline & capacity

Definition

The ability to produce accurate revenue forecasts using detailed operational and commercial data of current and future occupancy, anticipated fee income and capacity utilisation over a period of up to 12 months, using referral data, customer relationship management pipeline information, expected admissions and discharges, known occupancy changes, attrition and available capacity.

Inputs

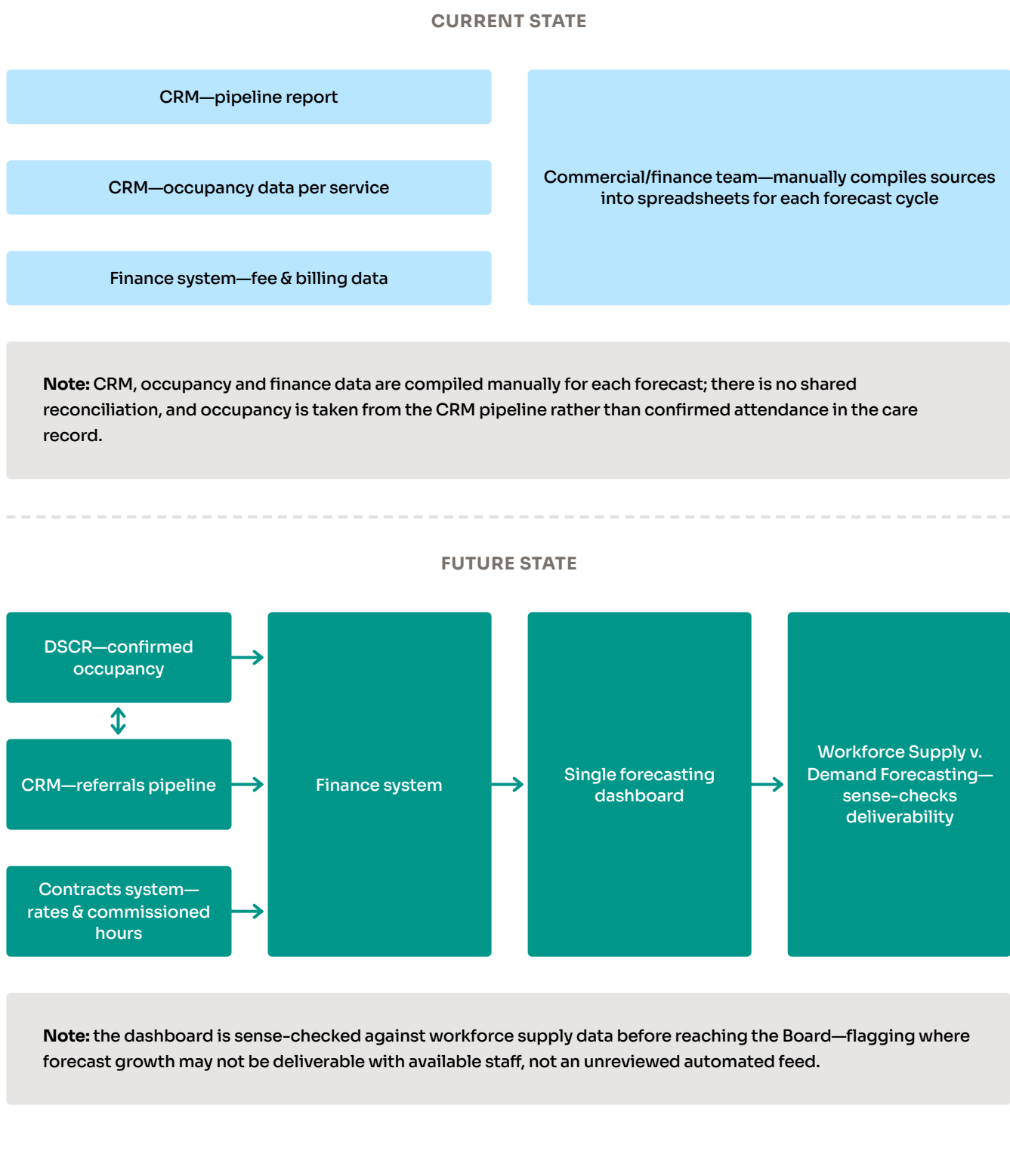
- Referrals pipeline data (stage, likelihood of conversion, expected start date)
- Current occupancy/capacity by service and location
- Commissioned/contracted hours and rates by placement
- Historical conversion rates by referrer/local authority/Integrated Care Board
- Void/vacancy data and expected discharge or exit dates
- Fee levels and uplift/negotiation status per contract
- Workforce supply data, to sense-check deliverability

Expected outcomes and measures of success

- **Organisational:** Improved operational and financial control through more accurate forecasting
- Clarity of projected occupancy, referral conversion, capacity and anticipated fee income
- Identifying gaps earlier, planning staffing and resources more effectively
- Improved cashflow forecasting

- **Strategic:** Improved long-term business planning through a clearer view of future occupancy, demand, income and risk
- Supports board-level decision-making for growth, investment and financial sustainability

Interoperability



Commissioning: local authorities and ICBs

Why this domain is important

This domain is not a description of local-authority best practice in isolation. It describes the digital relationship between commissioners and providers. Some functions here, such as safeguarding referrals and market oversight, are specifically local-authority responsibilities; others, such as commissioned activity reconciliation and outcomes reporting, are shared with or led by ICBs. In the current state, providers may submit similar information through different portals, formats and thresholds for each authority; safeguarding referrals can become one-way transactions and contract monitoring may count activity without connecting it to outcomes, cost or sustainability.

The future state is based on common definitions, proportionate national consistency and two-way information flows. Providers should be able to reuse trusted evidence from their operational systems, commissioners should be able to see agreed performance and outcomes and both parties should retain visibility of safeguarding and contract actions. The route to improvement is not a single national IT system. It is agreement on the data, standards, responsibilities and interfaces that different systems must support.

The financial pressures reported by ADASS and the LGA make efficiency important, but they also increase the risk that digital investment is treated only as a route to reduce commissioned hours. [6] [7] Neighbourhood Health guidance provides a practical opportunity for local authorities, ICBs and providers to co-design joined-up information around the person. [10] The expected value is fewer duplicate returns, quicker resolution of issues, more informed market oversight and commissioning decisions based on outcomes and sustainable delivery rather than activity alone.

How to read the current and future state

The current-state diagram shows commissioner requirements and provider evidence in separate systems, with manual submission and limited feedback. The future state should show standardised data fields, secure exchange and information returning to the provider. The benefit comes from a shared evidence base and clearer accountability on both sides.

#1 — Contract monitoring & KPI compliance

Definition

How commissioners and providers jointly assure that commissioned support is safe, delivers agreed outcomes rather than simply counting hours, meets statutory and contractual responsibilities, is funded fairly and sustainably, and builds the mutual evidence base commissioners need to trust provider performance.

Inputs

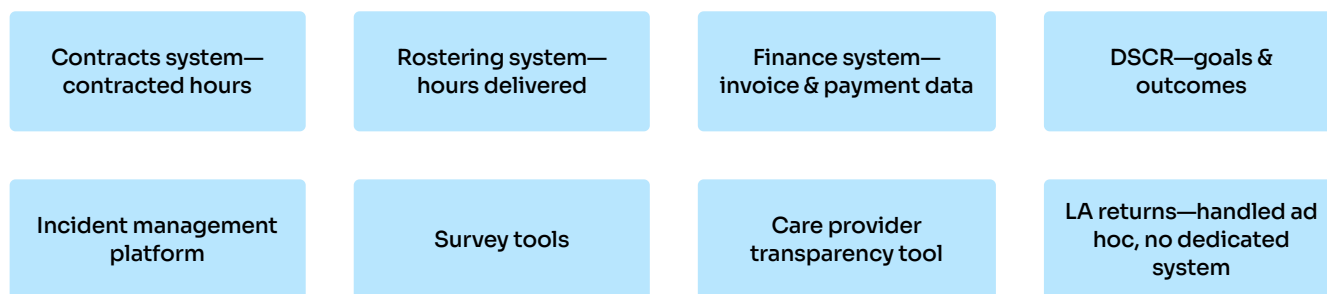
- Contracts, service specifications, key performance indicators and procurement documentation
- Contracted hours, delivered hours, invoicing and payment data
- Care and support plans, outcome records and feedback
- Safeguarding, incident, complaints and quality information
- Compliance: Care Act, Care Quality Commission (CQC) and non-CQC regulation
- Cost-of-care evidence and sustainable funding information

Expected outcomes and measures of success

- **Organisational:** Two-way contract compliance, with clear evidence that both provider and commissioner are meeting their responsibilities
- Achievement of agreed outcomes for each person and service, tracked consistently against contracted key performance indicators
- Timely resolution of contractual, quality, payment and funding issues
- **Strategic:** Evidence that outcomes remain realistic within available funding
- Provider and market sustainability with a fair cost-of-care approach
- Stronger, evidence-based negotiating position with commissioners

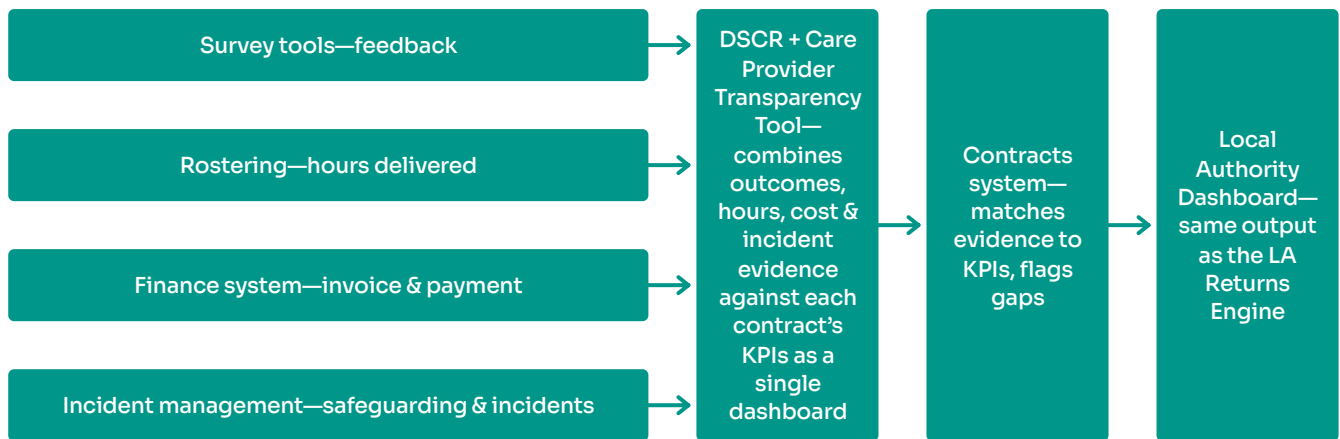
Interoperability

CURRENT STATE



Note: these eight systems hold the full evidence base for contract compliance between them, but nothing cross-references them—a commissioner query means manually pulling from each system separately, with no shared view of whether KPIs are actually being met.

FUTURE STATE



Note: this is the same evidence base as the LA Returns & Compliance Reporting diagram (Commercial #3), viewed from the commissioner-facing KPI side rather than the return-submission side—the two should be cross-referenced, not built as separate systems. A named individual still reviews flagged gaps before any commissioner conversation.

#2 — Safeguarding, reporting & information sharing

Definition

Ensuring safeguarding concerns are identified, escalated, and reported accurately and in a timely manner, with clear information sharing across internal and external teams, local authorities, and regulators to support appropriate action and reduce risk of harm, including bidirectional information sharing so providers retain visibility once a concern has been escalated, and ensuring historical safeguarding information travels with the person if they move between services or providers.

Inputs

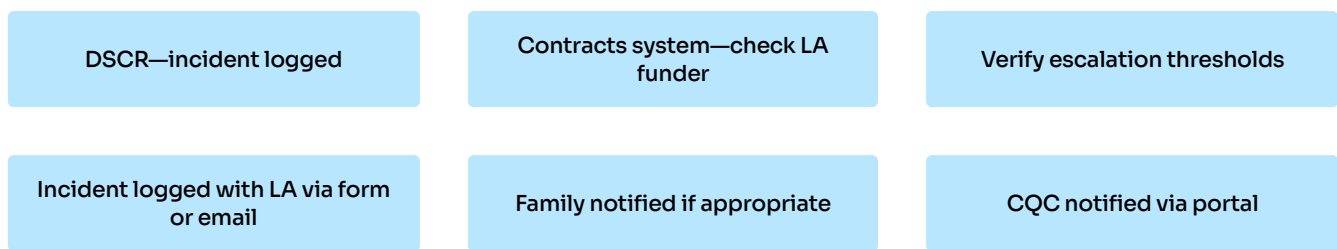
- Safeguarding concern reports raised by staff at the point of identification
- Escalation criteria and thresholds for internal vs external (local authority/regulator) reporting
- Local authority contact and referral routing data
- Care Quality Commission notification requirements relevant to safeguarding
- Historical safeguarding records for the person
- Feedback/outcome data from local authorities on referrals made

Expected outcomes and measures of success

- **Organisational:** Reduction in time between a safeguarding concern being identified and reported to the appropriate local authority
- Fewer instances of concerns being misdirected or delayed due to incorrect local authority routing
- Improved outcomes and visibility for providers on the status of referrals
- **Strategic:** Stronger, more consistent safeguarding practice across the sector, supported by clearer information-sharing standards between providers and local authorities

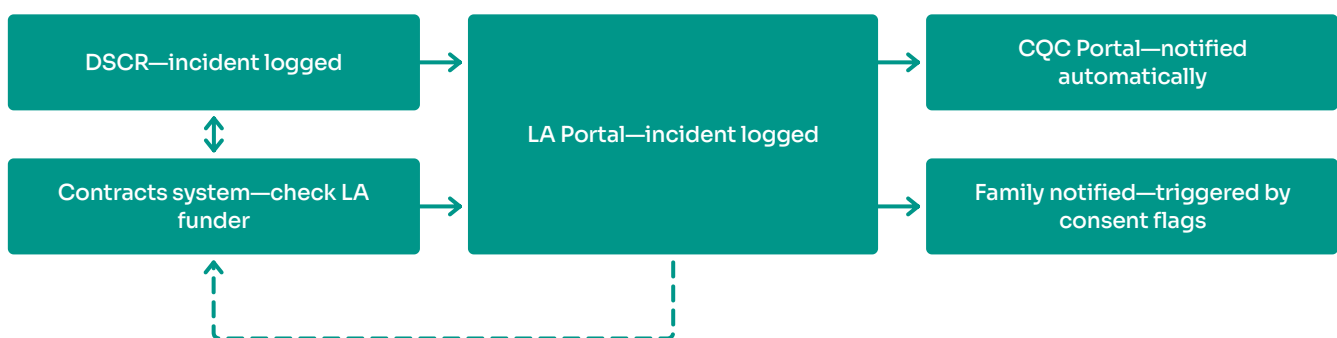
Interoperability

CURRENT STATE



Note: some providers use non-integrated incident platforms, adding a step. Historical safeguarding records are held per-provider today and don't travel with the person if they move between services—the same cross-provider gap flagged as aspirational in the DBS/Compliance diagram.

FUTURE STATE



Note: with standardised thresholds, incident logging could alert automatically for when and to whom to escalate. The LA Portal returns outcome/feedback directly to DSCR (dashed), closing the loop instead of providers chasing for status. Family notification is triggered by consent flags already in the care record, not a case-by-case judgement call.

#3 — Market intelligence & risk monitoring

Definition

The ability to use local and national data to understand the shape, stability and future direction of adult social care markets, including monitoring risks linked to local authority finances, fee levels, historic and current fee uplifts, commissioning behaviour, local authority solvency and wider demographic or market pressures.

Inputs

- Local authority budget and financial data (published accounts, Section 114 notices, spending reviews)
- Historic and current fee rate and uplift data by local authority/Integrated Care Board

- Local authority commissioning intentions and market position statements
- Demographic data
- Occupancy and void data across own services
- National and sector data sources (Care Quality Commission state of care reports, Association of Directors of Adult Social Services budget surveys, Office for National Statistics demographic data, Skills for Care workforce data)
- Competitor/market supply data

Expected outcomes and measures of success

- **Organisational:** Improved operational understanding of local adult social care markets
- Identify areas of opportunity or risk earlier
- Regular updating of local market profiles, risk dashboards and reports
- **Strategic:** Better-informed decision-making on growth, investment and exit strategies
- A more informed approach to assessing market sustainability, future demand, revenue opportunity and financial risk exposure

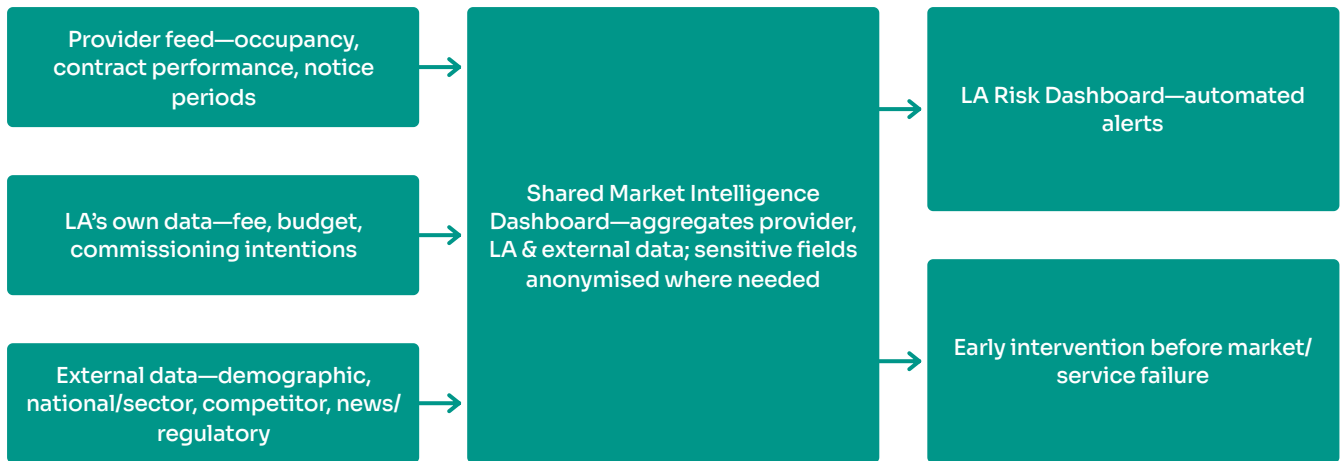
Interoperability

CURRENT STATE



Note: provider data is typically only shared with the LA reactively; demographic, competitor and national/sector data are monitored separately with no standard cadence or format across sources.

FUTURE STATE



Note: with standardised data-sharing agreements, provider, LA and external market data combine into one risk view—enabling earlier intervention than today's fragmented, reactive monitoring. Sensitive fields are anonymised before aggregation.

People

Why this domain is important

Recruitment, right-to-work checks, learning, payroll, rostering and the care record often maintain different versions of the same workforce information. Managers may know a worker has been recruited but not whether every check, competence and deployment requirement is complete. The current state therefore creates delay, repeated data entry and avoidable compliance risk.

The future state uses a shared worker identity and agreed data fields across the recruitment and employment journey. Information about role, location, checks, expiry dates, skills and availability can then support onboarding, deployment and assurance without removing human oversight. Artificial intelligence may help identify patterns or automate routine steps, but decisions affecting applicants and staff require transparent criteria, bias controls and accountable review.

Skills for Care estimated 96,000 vacant posts in adult social care in 2025/26, a vacancy rate of 6.2% and the lowest rate in a decade. Its Digital Skills Framework and digital-readiness resources also show that capability and confidence require deliberate support. [9] [21] [22] Care England's Adult Social Care Insights report found that providers commonly protect continuity through overtime, agency cover, task redistribution and management cover, while staff are receptive to technology where it reduces duplication and improves safety or deployment. [3] The expected return is faster recruitment, safer deployment, fewer lapsed checks, better workforce planning and reduced reliance on expensive short-notice cover.

How to read the current and future state

The current-state diagrams show repeated worker records and manual checks across systems. The future state connects the required data while preserving role-based access. The improvement comes from having one reliable view of whether a worker is eligible, competent and available for the support they are asked to provide.

#1 — Recruitment pipeline & vacancy management

Definition

How an organisation manages vacancies and the end-to-end recruitment pipeline, including time to hire, conversion rates and recruitment effectiveness, using integrated processes and appropriate automation or artificial intelligence in a fair, unbiased manner.

Inputs

- Applicant tracking system and external recruitment sources
- Workforce plans, vacancies, job descriptions and recruitment processes
- Organisational policies, national requirements and safer recruitment checks
- Training, onboarding and skills-gap assessment
- HR, payroll, learning management, rostering, finance and contract data
- Person-led requirements from care and support plans

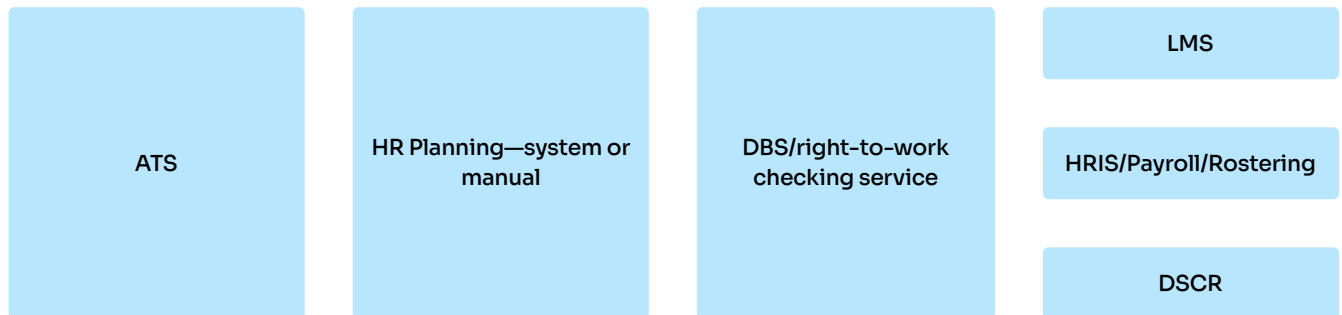
Expected outcomes and measures of success

- **Organisational:** Reduced time to recruit and time to complete onboarding
- Improved vacancy, turnover and first-month attrition rates

- Reduced agency usage and cost
- Improved application-to-hire conversion rates
- **Strategic:** Recruitment cost sustained in line with commissioned care rates
- Greater workforce stability and resilience
- Improved organisational reputation as an employer

Interoperability

CURRENT STATE



Note: the ATS, DBS checking service, LMS, HRIS/Payroll/Rostering and DSCR each hold their own record of the same new starter, so managers re-key the same details system by system.

FUTURE STATE



Note: with a shared candidate/employee ID across ATS, DBS checking, LMS, HRIS, Payroll, Rostering and DSCR, one hire event updates every system automatically—matched against real contract/funding capacity and person-centred need, not just headcount. HRIS leaver/sentiment alerts (dashed) feed back into workforce planning.

#2 — DBS & compliance tracking

Definition

Ensuring staff Disclosure and Barring Service (DBS) checks and other mandatory compliance requirements are tracked, up to date, and evidenced, with visibility of expiry dates and renewal status to reduce risk and support regulatory compliance.

Inputs

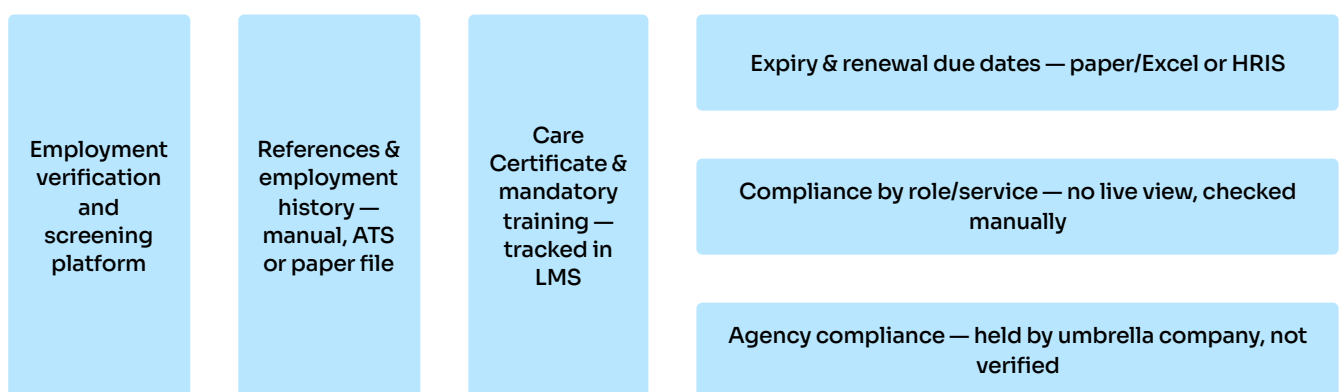
- DBS check records (initial and renewal)
- Other mandatory pre-employment and ongoing compliance checks (right to work, references, Care Certificate)
- Expiry and renewal due dates per staff member
- Compliance status by role and service
- Agency worker compliance data
- Historical compliance breach or near-miss data

Expected outcomes and measures of success

- **Organisational:** Efficient and timely recruitment, with reduced delays caused by chasing compliance status
- Real-time visibility of who is compliant and deployable
- Reduction of agency spend caused by lapsed checks
- **Strategic:** Improvement in quality of care, underpinned by confidence in safe recruitment
- Stronger regulatory assurance and reduced organisational risk exposure

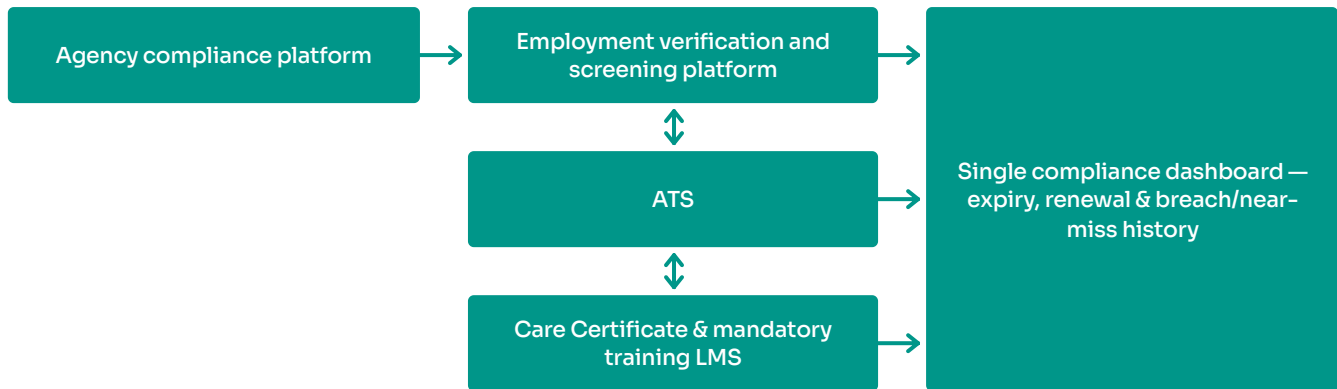
Interoperability

CURRENT STATE



Note: which system holds DBS/RTW checks (incl. certificate numbers & update service status) varies by provider — some use a dedicated checking service (e.g. Konfir), others rely on fields within the ATS/HR system. Breach/ near-miss history has no consistent system home across providers seen so far.

FUTURE STATE



Note: with a shared compliance dashboard spanning DBS/RTW, references, Care Certificate and agency checks, gaps by role/service surface automatically. Longer term, a sector-wide social care passport could let a worker's verified status move with them between providers.

#3 — Visa sponsorship & international recruitment

Definition

The ability to manage the process of recruiting staff from overseas, including sponsorship compliance, visa application tracking, right-to-work verification, and onboarding, through to ongoing compliance monitoring for sponsored workers (salary thresholds, role/skill requirements, reporting duties to the Home Office).

Inputs

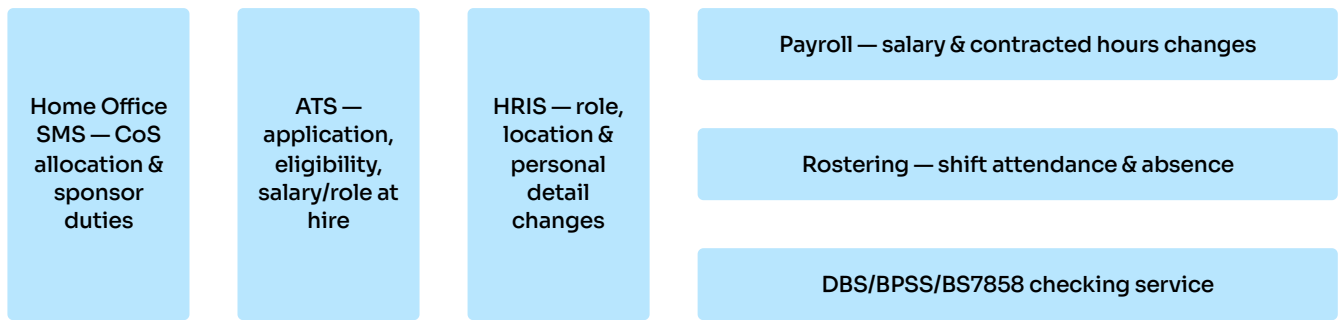
- Sponsorship licence and Home Office compliance requirements
- Candidate application, eligibility, and right-to-work data
- Visa status, expiry, and renewal dates per sponsored worker
- Salary and role data needed to meet sponsorship thresholds
- Pre-employment compliance checks (Disclosure and Barring Service, and security-screening standards including the Baseline Personnel Security Standard and BS7858)
- Recruitment pipeline and time-to-hire data for international candidates

Expected outcomes and measures of success

- **Organisational:** Reduction in sponsorship licence compliance breaches or Home Office audit findings
- Reduced time-to-hire and administrative burden
- Fewer lapses in visa status leading to unplanned staff absence
- **Strategic:** Greater sector resilience against workforce shortages through safer international recruitment
- A consistent standard for sponsorship compliance data that reduces risk across providers

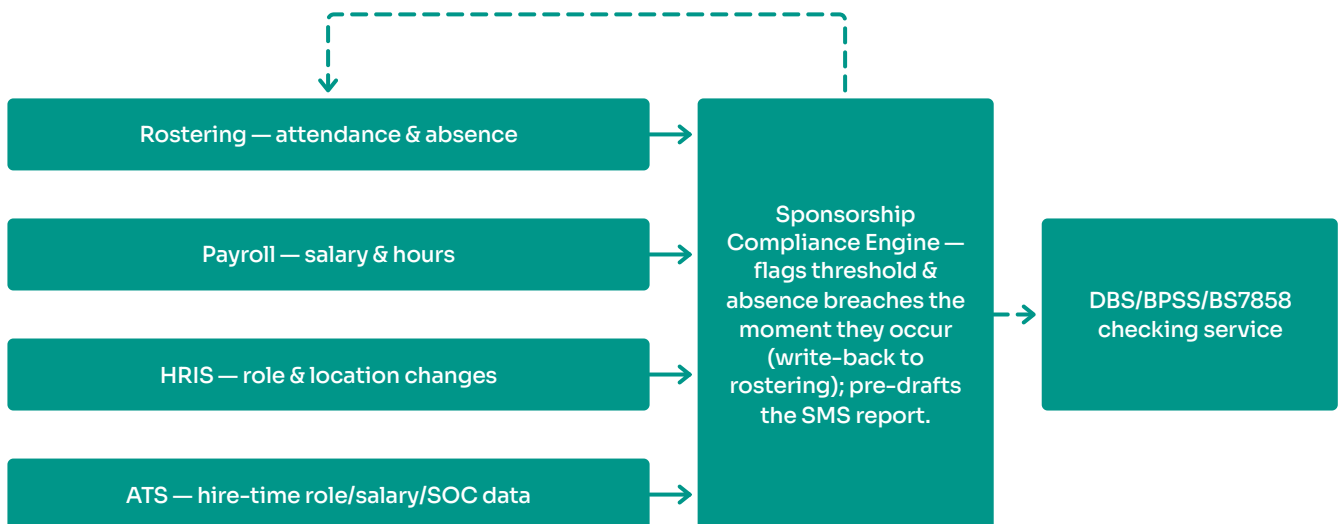
Interoperability

CURRENT STATE



Note: Rostering, Payroll and HRIS already hold the signals for reportable events (10+ day absence, salary or role changes) but none of it is linked to Home Office reporting deadlines. Visa/CoS/BRP expiry sits in paper/Excel, and international time-to-hire is tracked separately in the ATS. This domain has no SME interview input yet.

FUTURE STATE



Note: Rostering, Payroll, HRIS and ATS already hold this signal today, disconnected. Feeding it into one engine catches breaches at the moment they occur and drafts the report — closing the detection gap, not the submission step.

Regulatory assurance

Why this domain is important

The Regulatory assurance domain describes how providers assemble and use evidence for safe, effective and person-led care. Medication, care planning, staffing and safer-recruitment information is usually available, but it may be spread across clinical, care, workforce and audit systems. The result is repeated collation for assurance and inspection, with limited ability to identify cross-cutting risk early.

The future state keeps the underlying accountability with the provider while making evidence traceable, current and easier to combine. Version history, audit trails, competence data and incident information can be brought together for managers and regulators without creating a parallel inspection database. Digital evidence should support professional judgement; rating prediction or automated flags should never become an unchallengeable regulatory decision.

CQC has recognised that digital records are increasingly central to capturing and sharing information and that technology can support communication and learning across a system. [15] This supports the proposed mechanism, but there is not yet evidence in this report that the model will improve ratings. The expected value is less duplicate preparation, clearer assurance, earlier identification of gaps and more proportionate use of evidence already held by providers.

Regulatory assurance is broader than CQC alone. CQC remains the principal regulator for adult social care in England. Where an organisation also operates children's social care, supported accommodation, education or other services within Ofsted's remit, the same digital estate may need to support distinct Ofsted evidence requirements. The digital-excellence principle is not that both regulators should require identical information, but that trusted provider-held evidence should be reusable, proportionate and capable of supporting the relevant framework without unnecessary duplication. [25]

This domain should be read alongside Quality & improvement. Quality & improvement is where the organisation assures, learns and acts internally; Regulatory assurance is how the relevant evidence is made available externally with clear provenance, access controls and human accountability.

How to read the current and future state

The current-state diagrams show regulatory evidence reassembled from separate systems. The future state connects the underlying records, checks and actions so each item can be traced to accountable source data. The improvement is stronger assurance and less re-entry, not automated compliance.

#1 — Medication safety & MAR documentation

Definition

How an organisation delivers safe medication support through medication administration records, as-needed (PRN) medication protocols, medicines-error reporting, risk management, storage and administration processes.

Inputs

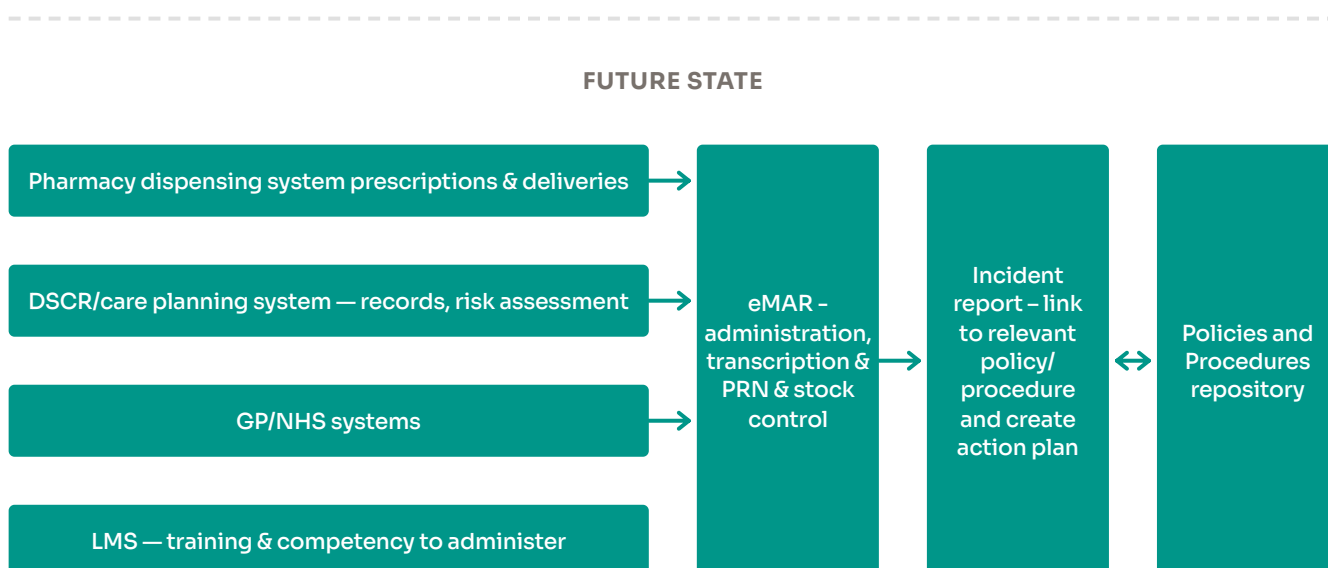
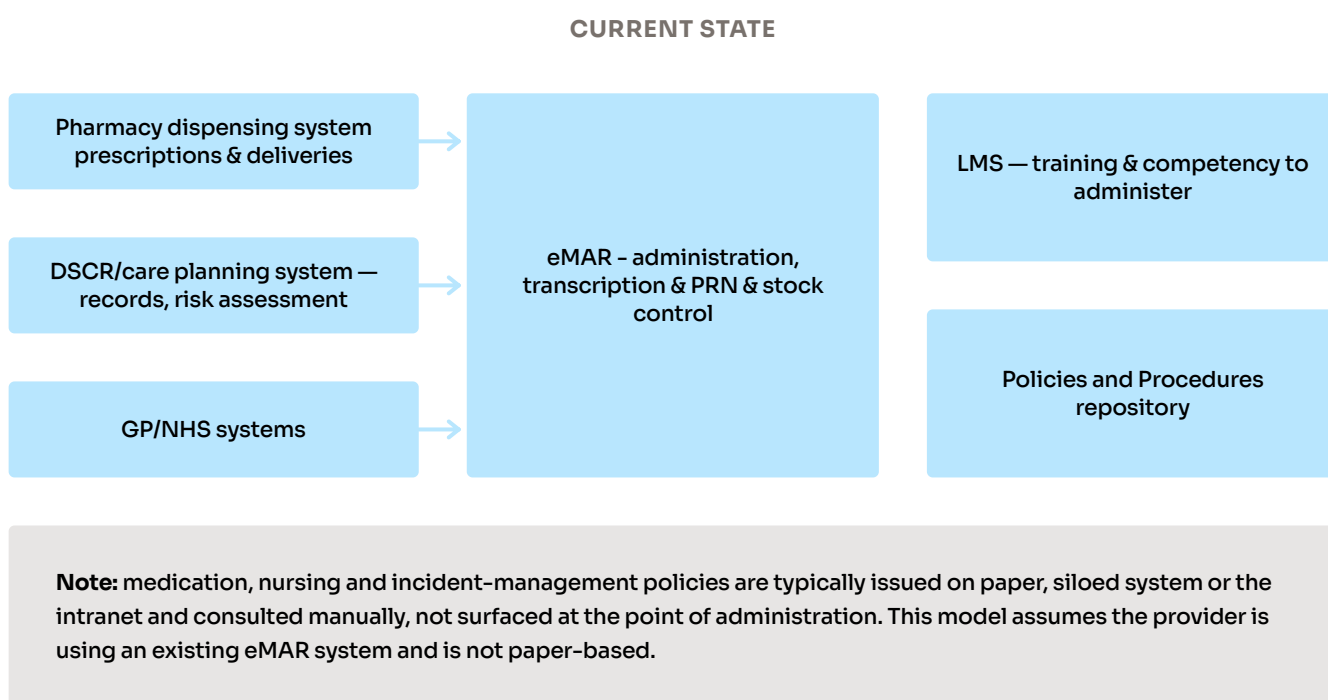
- Prescriptions, pharmacy dispensing and medicine delivery information
- Medication administration records (paper or electronic), including transcription and as-needed medication protocols
- Care and support records, risk assessments and health information

- Medication, delegated nursing, health & safety, and incident-management policies
- Training and competency assessment
- Storage, stock control and disposal records

Expected outcomes and measures of success

- **Organisational:** Compliance with prescribed medication and agreed protocols
- Reduction in medication errors, omissions and near misses
- Timely identification, escalation and learning from errors
- **Strategic:** Improved health outcomes and reduced avoidable illness
- Assurance that only trained and competent staff administer medicines

Interoperability



#2 — Care planning & risk assessment quality

Definition

A comprehensive, person-led plan to care for and support an individual which identifies and minimises risk and maximises independence, ensuring care plans and risk assessments accurately reflect current needs, preferences and goals, and are reviewed and updated as circumstances change.

Inputs

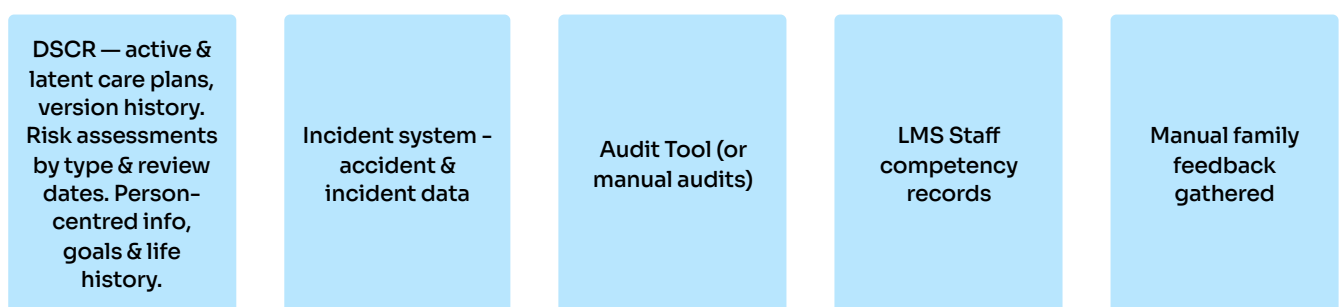
- Active and latent care plans, with version history
- Risk assessments by type and review dates
- Person-led information: preferences, goals, communication needs, life history
- Incident and accident data
- Feedback from the person supported and their family
- Audit findings on care plan and risk assessment quality

Expected outcomes and measures of success

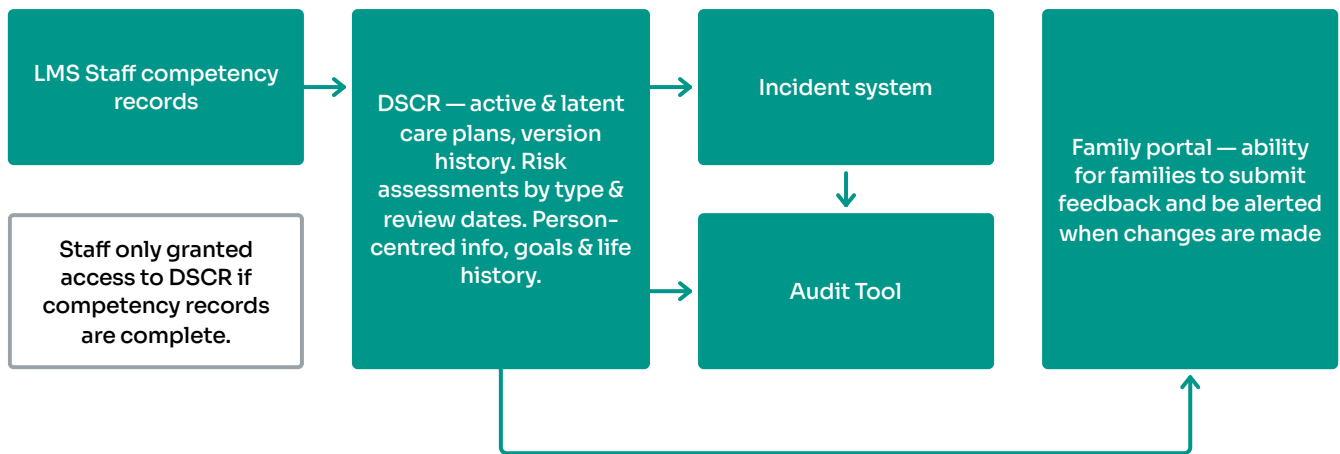
- **Organisational:** More consistent, complete, and up-to-date care plans and risk assessments across services
- Reduction in incidents linked to unassessed or poorly managed risks
- Reduction in overdue or lapsed reviews
- **Strategic:** Effective, positive outcomes for people supported
- Stronger regulatory assurance that care planning and risk management are person-led and embedded in practice

Interoperability

CURRENT STATE



FUTURE STATE



#3 — Early warning system to identify services at risk of a poor culture and potential abuse

Definition

The ability to bring together organisational indicators across leadership, workforce, quality and people's experience into a single early-warning view, so that patterns suggesting a risk of closed culture, weakening governance, or potential abuse can be identified and acted on before harm occurs. No single indicator is a reliable signal on its own; the value lies in monitoring indicators collectively and recognising when several begin to move together, complementing rather than replacing professional judgement and CQC inspection.

Inputs

- **Leadership & governance:** Registered Manager vacancies/turnover, span of control, Board oversight of quality and safety, senior leadership visibility
- **Workforce:** staff turnover, sickness, agency reliance, supervision compliance, mandatory training compliance
- **Quality:** internal audit performance, improvement action completion, complaints, safeguarding concerns, CQC notifications, medication incidents
- **People's experience:** family concerns, social worker/professional feedback, advocacy involvement, restrictive practice and physical interventions, voice of people supported
- **Environmental & operational:** service isolation, environmental quality, occupancy pressures, complexity of people supported
- Daily records and other regular recording
- Reports from external professionals, for example members of the local learning disability team

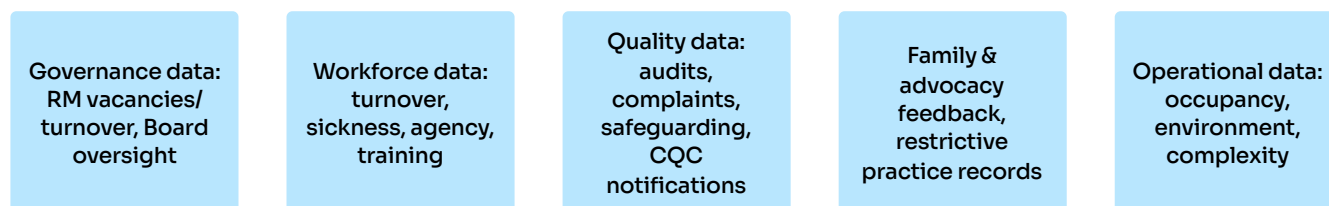
Expected outcomes and measures of success

- **Organisational:** Earlier identification of organisational drift, before individual concerns become embedded practice
- Reduction in time between weakening organisational conditions emerging and improvement action being triggered
- Fewer services reaching crisis point before intervention

- **Strategic:** Stronger Board and regulatory assurance that closed cultures and abuse risk are identified proactively, not only after harm occurs
- A shared, sector-recognised methodology that complements CQC inspection by focusing on organisational conditions rather than individual compliance checks
- A contribution towards reducing the risk of serious incidents leading to harm or death, as one part of a wider safeguarding approach

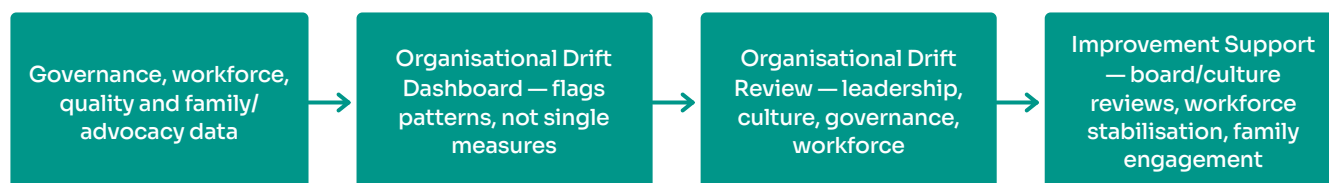
Interoperability

CURRENT STATE



Note: no shared view today — patterns across workforce, safeguarding, complaints and audit findings are not visible until concerns are already significant.

FUTURE STATE



Estates

Why this domain is important

Estates information is often divided between asset registers, contractor records, certificates, reactive maintenance systems, incident logs and local spreadsheets. A property can therefore appear compliant in one system while an overdue action or recurring fault is visible elsewhere. The problem is primarily one of traceability and accountable follow-through.

The future state links each asset and location to its statutory checks, faults, contractor activity, risk assessments and open actions. Automated reminders and escalation can identify overdue work, while named owners retain responsibility for triage and closure. Safety systems can feed relevant alerts into operational workflows, but they should not create uncontrolled monitoring or replace professional assessment.

The report has not identified a sector-wide evaluation that quantifies the return from this exact estates model. The case is therefore based on a clear operating mechanism: one traceable record reduces the chance of missed checks, repeated faults and fragmented evidence. The expected value is quicker response to safety-critical issues, fewer overdue compliance items, better capital planning and stronger assurance to people, boards, regulators and insurers.

How to read the current and future state

The current-state diagrams show asset, certificate, contractor and action information held separately. The future state brings them together around the property or asset and routes exceptions to an accountable owner. The improvement comes from visibility and closure, not from digitising the register alone.

#1 — Planned preventative maintenance and compliance

Definition

How an organisation plans, delivers and evidences preventative maintenance and statutory property compliance, so that homes and workplaces remain safe, suitable, available and well maintained.

Inputs

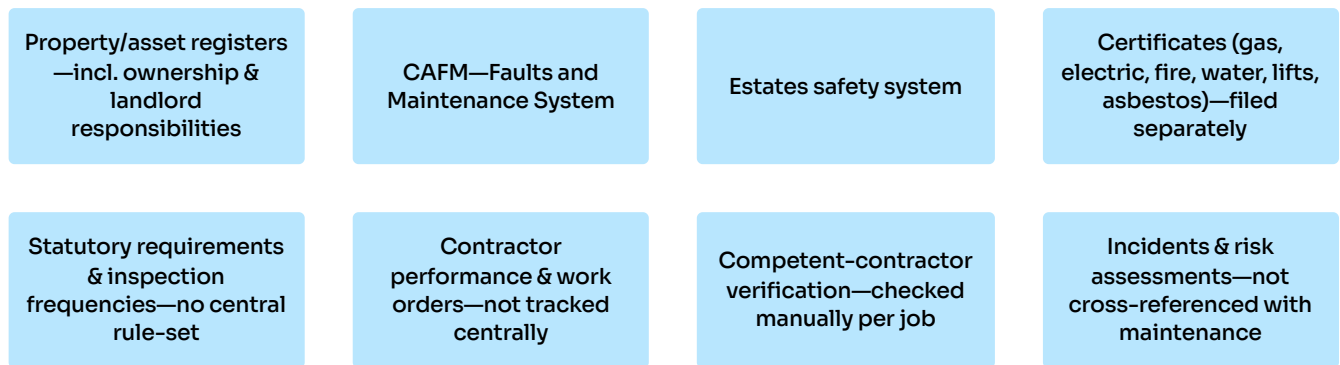
- Property, asset and equipment registers
- Statutory and regulatory requirements, inspection frequencies
- Maintenance schedules, servicing contracts, warranties
- Certificates for gas, electricity, fire safety, water hygiene, lifts, asbestos
- Responsive repairs, inspection findings, risk assessments

Expected outcomes and measures of success

- **Organisational:** Percentage of planned preventative maintenance and statutory checks completed on time
- Number and age of overdue, failed or missing compliance items
- **Strategic:** Reduction in repeat failures, emergency repairs and avoidable downtime

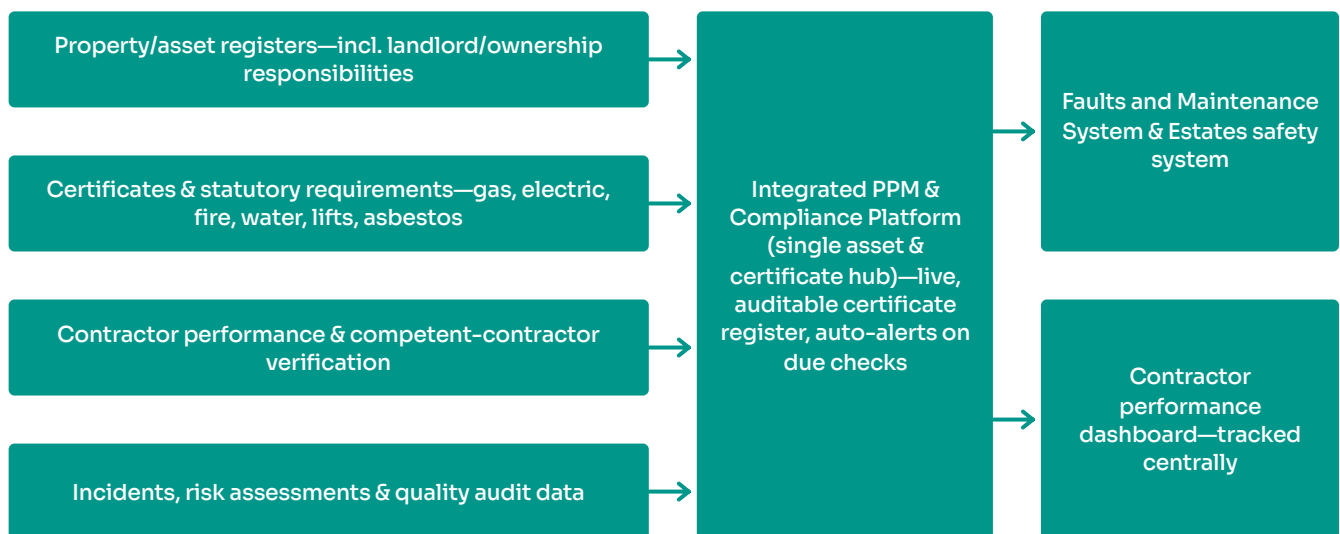
Interoperability

CURRENT STATE



Note: asset registers, certificates, contractor records and statutory requirements sit in separate per-site systems, tracked manually and disconnected from incident/risk data—so overdue items, expired certificates and defects are found late.

FUTURE STATE



Note: the certificate register auto-alerts on due/expiring checks and verifies contractor competency before dispatch. Incidents and quality audit data now feed the same platform, so a recurring defect or safety incident is visible alongside its maintenance history—not discovered separately.

#2 — Reactive maintenance triage

Definition

The ability to capture, prioritise, and route reactive maintenance issues as they arise across a property

portfolio, so that urgent or safety-critical issues are actioned quickly while lower-priority items are scheduled efficiently.

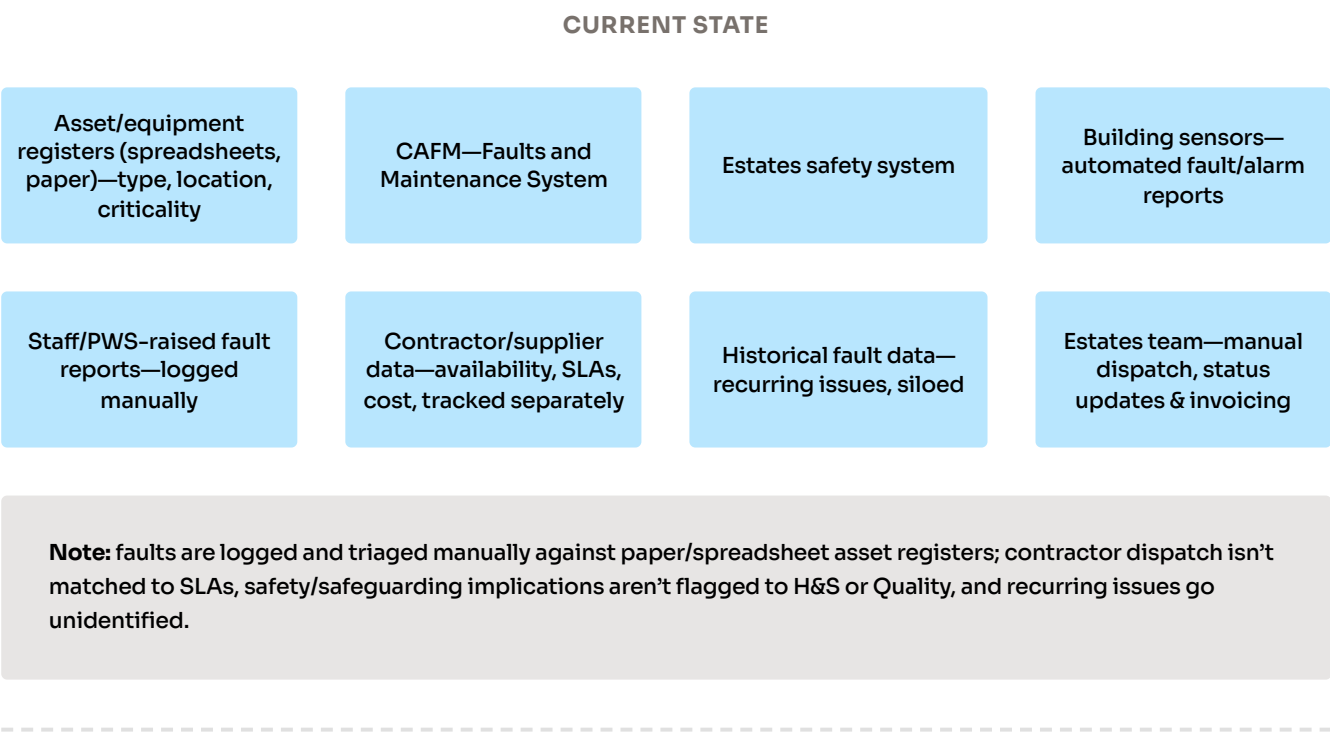
Inputs

- Maintenance/fault reports raised by staff, people supported, or automated building systems
- Asset and equipment data
- Risk/priority classification criteria
- Contractor and supplier availability, service level agreements and cost data
- Historical fault/incident data

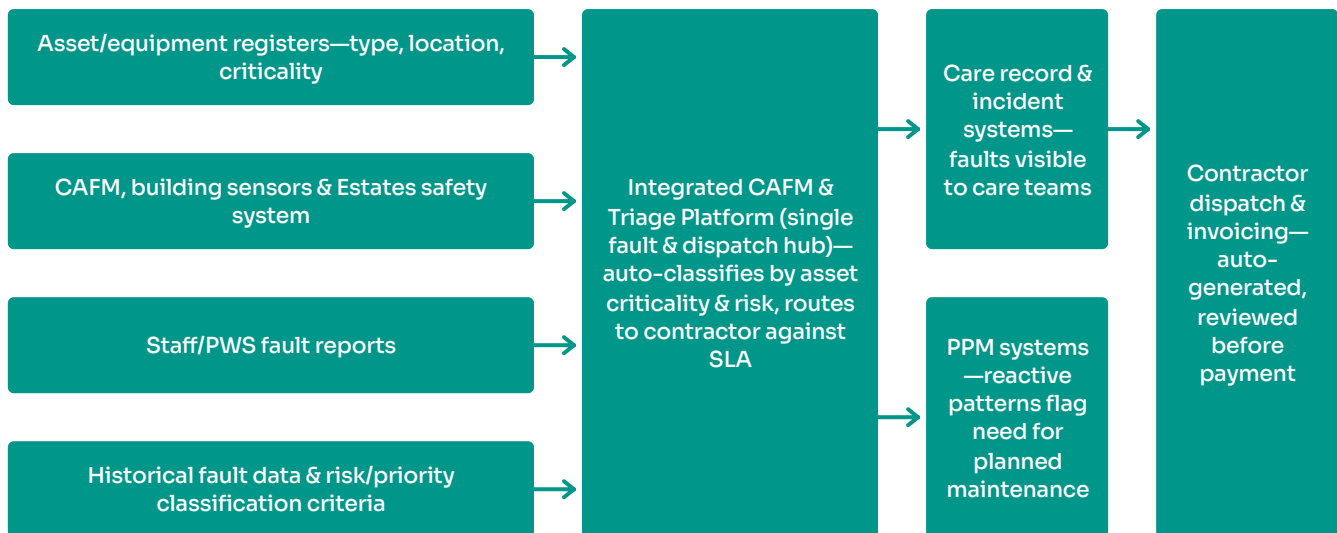
Expected outcomes and measures of success

- **Organisational:** Reduced time between a fault being reported and resolved
- Improved visibility for care teams on the status of reported issues
- **Strategic:** Better data to inform capital investment and planned maintenance decisions

Interoperability



FUTURE STATE



Note: auto-classification uses asset criticality and risk/priority rules to route faults and match contractor dispatch to SLA; invoicing is auto-generated but reviewed before payment, not auto-paid. Links to PPM and care/incident systems keep safety implications visible beyond Estates.

#3 — Safety systems integration

Definition

The ability to maintain accurate and auditable oversight of the systems, processes and controls used to manage safety across the organisation, distinct from planned preventative maintenance, focused on whether safety risks are being identified and managed through effective governance.

Inputs

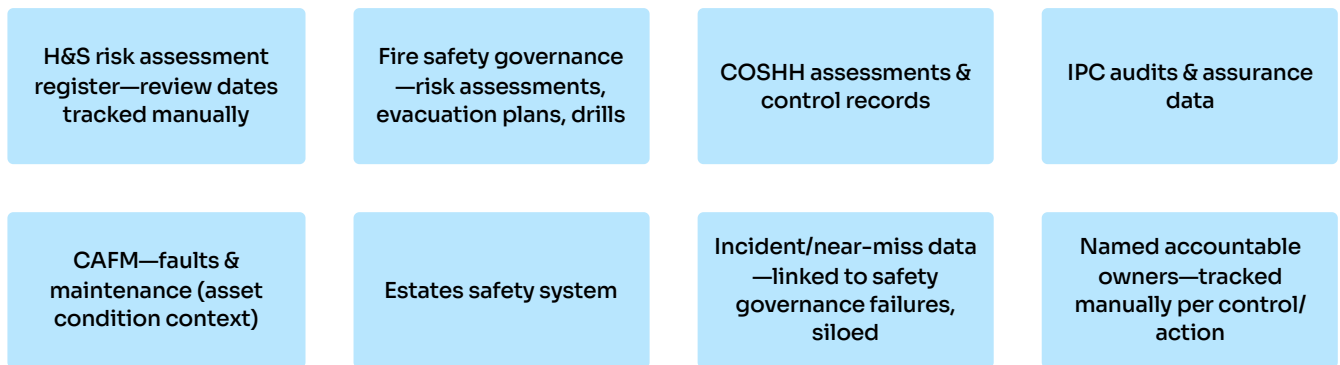
- Health and safety risk assessments and review dates
- Fire safety governance records
- Control of Substances Hazardous to Health (COSHH) assessments and control records
- Infection prevention and control audits
- Audit findings and open/overdue action logs
- Named accountable owners for each control/action

Expected outcomes and measures of success

- **Organisational:** Improved control of safety risks, with clear visibility of assessments, findings and overdue controls
- Early identification of unmanaged or recurring safety risks
- **Strategic:** Improved assurance that estate safety governance is effective, consistent and capable of reducing organisational risk

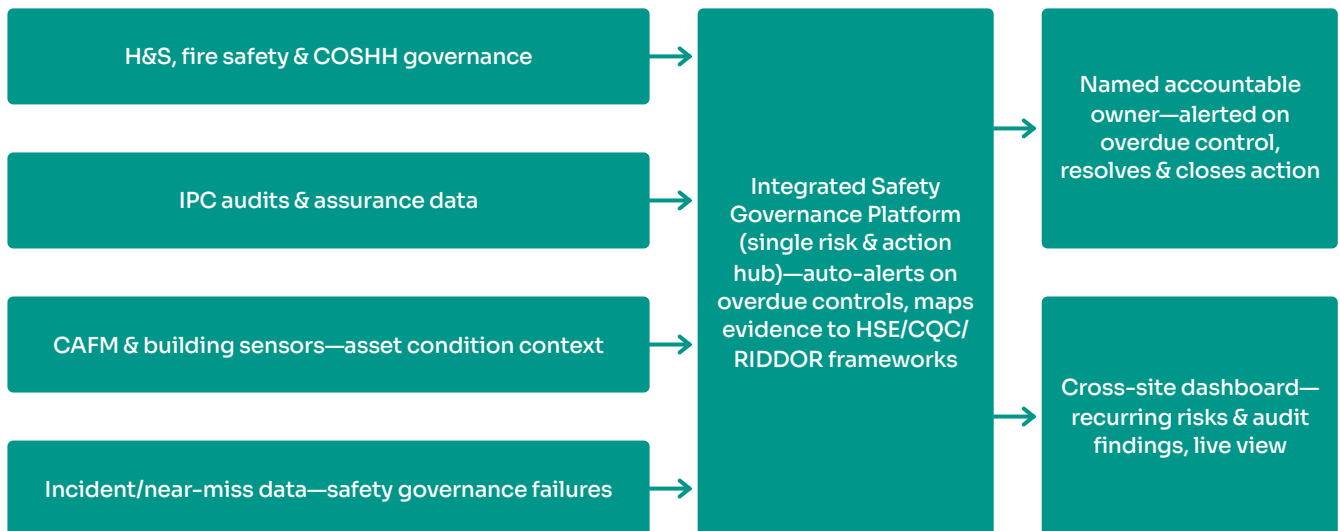
Interoperability

CURRENT STATE



Note: H&S, fire, COSHH and IPC governance sit in separate registers, disconnected from asset/CAFM data, incident data and named ownership. Regulatory evidence (HSE, CQC, RIDDOR) is compiled manually per site, so overdue controls and recurring risks surface late.

FUTURE STATE



Flag: overlaps Quality Assurance Auditing & Incident/Safeguarding Oversight—shared IPC & incident inputs.

Note: auto-alerts flag overdue controls to the named accountable owner for resolution, not automatic closure. This is at least the sixth diagram in this domain describing a similar fragmented-systems-to-single-platform shape—worth consolidating rather than maintaining separately.

Quality & improvement

Why this domain is important

Quality and improvement becomes reactive when audits, incidents, complaints, safeguarding, workforce, medication and cyber information are reviewed separately. Each system may be complete in itself while the organisation lacks a trusted view of recurring risk, action ownership and whether improvement has been sustained.

The purpose of this domain is continuous improvement, not inspection preparation alone. It should help the organisation understand experience and outcomes, test whether controls are working, learn from incidents and feedback, assign actions and confirm that improvement has been sustained. Regulatory returns and inspection evidence should flow from that work rather than becoming a parallel quality system.

The future state creates an organisation-wide governance view built from accountable source systems. Common definitions, audit trails and action ownership allow leaders to identify patterns, drill back to evidence and test whether actions have been completed. The purpose is not to centralise every record or replace local knowledge; it is to make risk, learning and improvement visible across services.

CQC's work on the impact of technology supports the role of digital records and shared information in communication and learning. [15] The Organisational Drift example in the maturity section is a proposed application of this logic, not a validated early-warning instrument. The expected value is earlier learning, stronger board assurance, less duplicate reporting and more consistent follow-through, with any predictive use subject to testing and professional judgement.

How to read the current and future state

The current-state diagrams show evidence held in separate systems and manually assembled. The future state connects the governance view while retaining the original accountable records. The improvement comes from pattern recognition, traceability and action, not from the dashboard itself.

#1 — Quality governance, assurance & improvement

Definition

How an organisation brings together internal audit, service review, feedback, complaints, incidents, safeguarding, workforce, medication and improvement actions to understand quality, learn and sustain change. Regulatory evidence, required returns and inspection readiness are outputs of this internal governance, not its sole purpose.

Inputs

- Externally imposed regulations, standards and assurance frameworks
- Internal quality audits, service reviews and action plans
- External inspections and information requests, including Care Quality Commission activity
- Survey, complaints, compliments and whistleblowing information
- Safeguarding, incidents, workforce, training and medication information

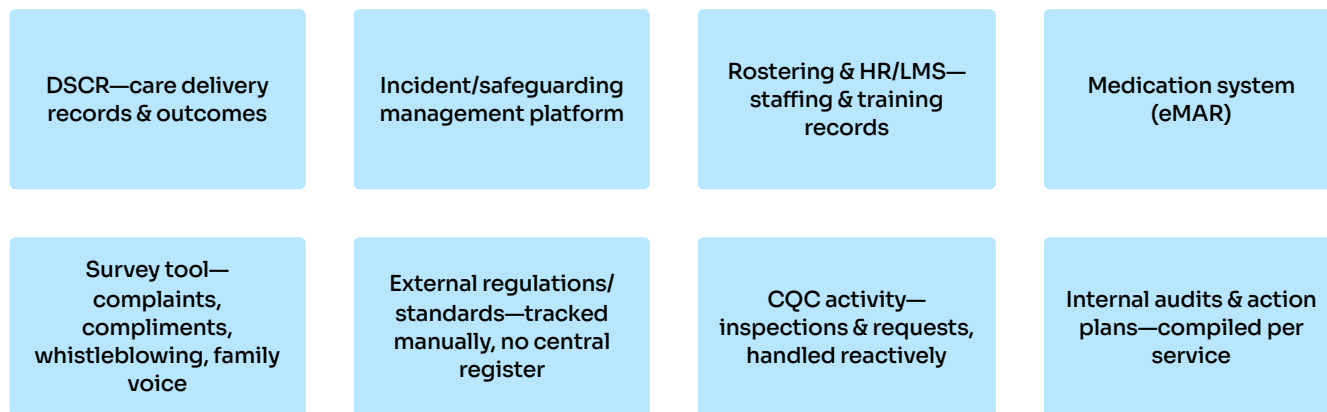
Expected outcomes and measures of success

- **Organisational:** Consistent, on-time completion of assurance activity and required returns, with clear evidence that improvement actions are completed and sustained

- A single organisational view of quality, compliance, risks and improvement actions
- **Strategic:** Stronger organisational learning and reduced quality, regulatory and reputational risk through earlier identification and sustained improvement

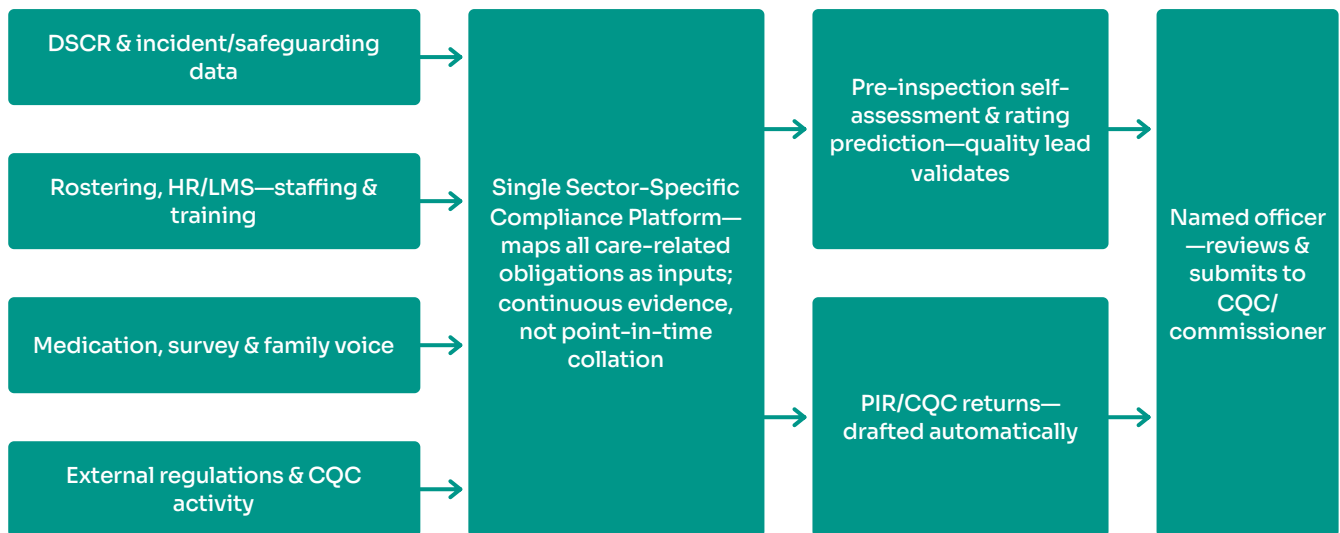
Interoperability

CURRENT STATE



Note: quality, safeguarding, workforce, training and medication data sit in separate systems; family/PWS voice, external regulatory requirements and CQC activity are tracked manually with no shared compliance view. HR and LMS records aren't always integrated.

FUTURE STATE



Note: the platform maintains continuous, mapped evidence for constant audit readiness. Self-assessment and rating predictions are reviewed by a quality lead, and PIR/CQC returns are reviewed & submitted by a named officer—not auto-submitted. This is the same evidence base as LA Returns & Compliance Reporting and Contract Monitoring & KPI Compliance, viewed from the inspection-readiness angle.

#2 — Cyber security, resilience & information governance

Definition

The ability to maintain accurate, auditable and proportionate oversight of cyber security and information governance across the organisation, including management of cyber incidents, breach reporting, and compliance with certifications such as Cyber Essentials and the Data Security and Protection Toolkit.

Inputs

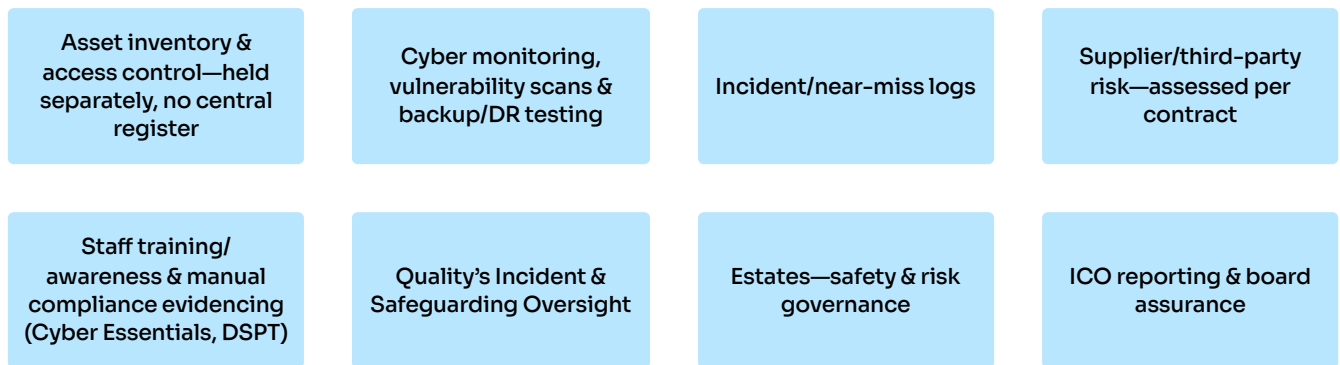
- Asset and system inventory across the organisation
- Access control and user permission records
- Data protection and information governance policies
- Cyber incident and near-miss logs
- Backup and disaster recovery status/testing records
- Third-party and digital supply partner risk assessments and contracts
- Vulnerability scan and penetration test results

Expected outcomes and measures of success

- **Organisational:** Improved oversight of cyber security, data protection and information governance risks
- Early action on vulnerabilities and breaches before they create wider risk
- **Strategic:** Improved assurance that cyber security and information governance arrangements are safe and compliant

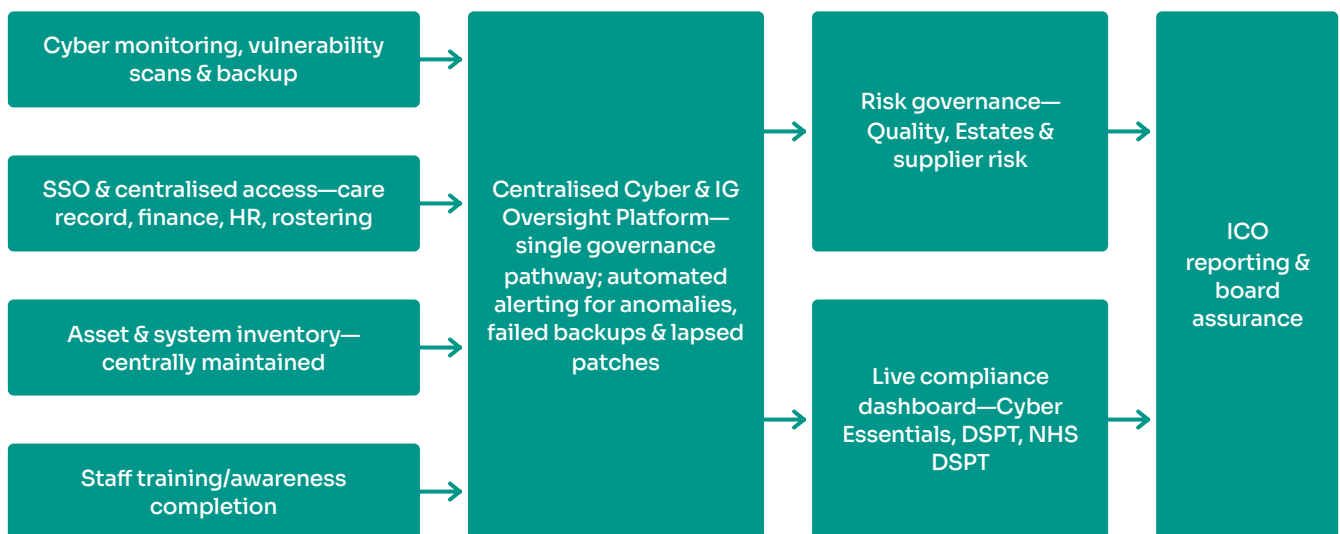
Interoperability

CURRENT STATE



Note: asset inventory, access control, monitoring, backup/DR and supplier risk sit in separate silos, disconnected from Quality's and Estates' risk governance. Asset records and staff training completion aren't centrally tracked, and evidencing certifications (Cyber Essentials, DSPT) is manual.

FUTURE STATE



Note: automated alerting flags anomalies, failed backups and lapsed patches—a named security lead/DPO still makes escalation and breach-notification decisions; this is not autonomous ICO reporting. Asset inventory and staff training now feed the same platform as monitoring and access data, closing gaps that weren't visible before.

#3 — Staffing level compliance & safe staffing checks

Definition

How an organisation assures, in real time and retrospectively, that each service has the right number and

mix of competent staff to meet individual needs, contractual requirements and identified risks safely.

Inputs

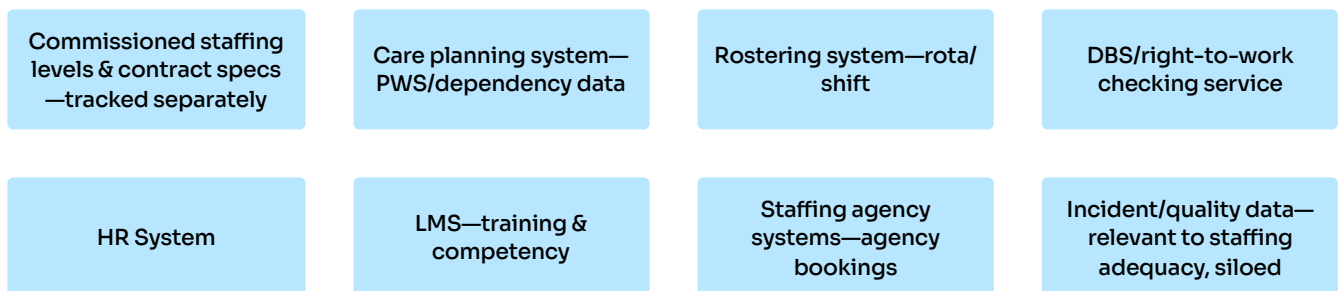
- Commissioned staffing levels, specifications and agreed models
- Care plans, dependency, risk assessments and person-specific needs
- Rota, shift, attendance and absence information
- Staff skills, training, competency and right-to-work information
- Vacancies, agency bookings, overtime and on-call availability

Expected outcomes and measures of success

- **Organisational:** Percentage of shifts meeting required staffing numbers and skill mix
- Unfilled shifts, late cover and periods below safe staffing levels
- **Strategic:** Continuity of support and deployment of staff who know the person and meet their requirements

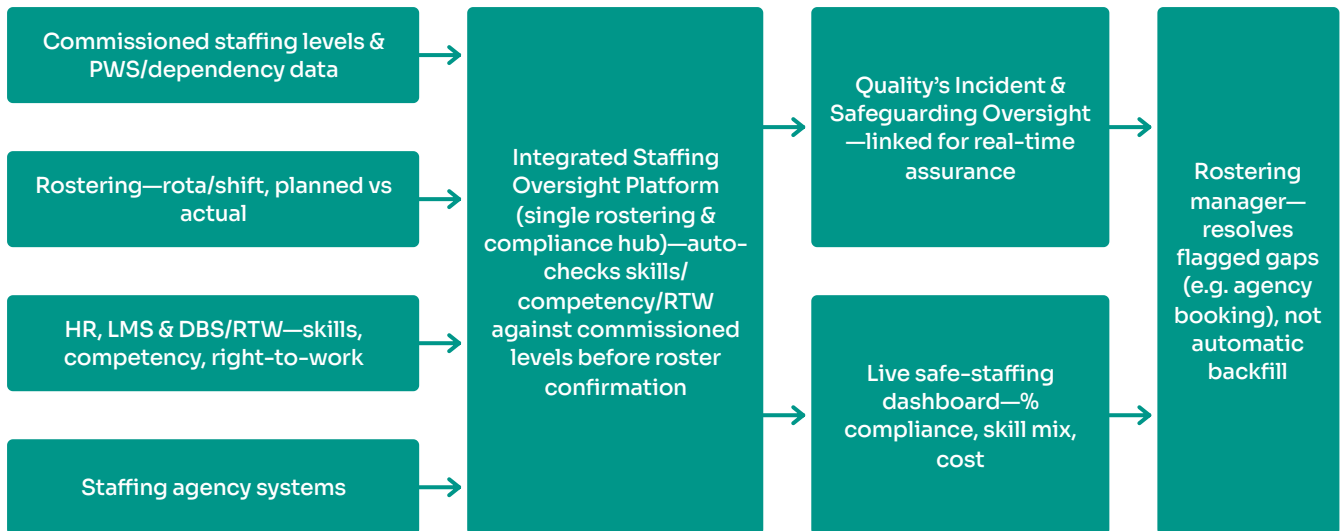
Interoperability

CURRENT STATE



Note: commissioned staffing levels, rota, skills/training, right-to-work, agency usage and incident data sit in separate systems, cross-checked manually against the contracted baseline—so staffing shortfalls and compliance gaps are usually found after the fact.

FUTURE STATE



Note: the platform blocks roster confirmation where skills, competency or right-to-work requirements aren't met against the commissioned baseline—a rostering manager still resolves flagged gaps, this isn't automatic backfill. Incident and quality data link back for real-time assurance.

#4 — Real-time risk & incident monitoring

Definition

The ability to capture incidents, accidents, and risk events as they happen and route them immediately to the right people and systems, including automated identification of events that meet statutory reporting thresholds, and predictive analytics to proactively prevent incidents from occurring.

Inputs

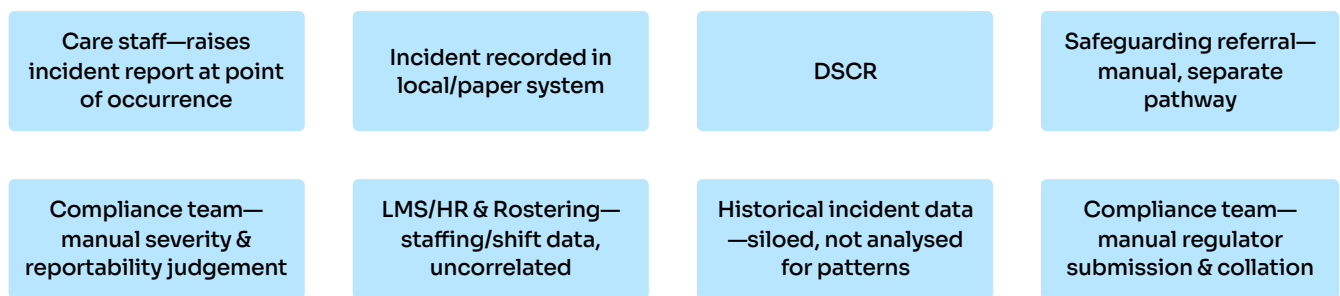
- Incident and accident reports raised by staff at the point of occurrence
- Risk classification criteria and regulatory reporting requirements
- Safeguarding referral criteria and escalation pathways
- Historical incident data for pattern/trend detection
- Staffing and shift data for correlation analysis

Expected outcomes and measures of success

- **Organisational:** Reduced time between an incident occurring and escalation/notification
- Fewer missed or late statutory notifications
- **Strategic:** Stronger regulatory confidence and demonstrable evidence of proactive risk management

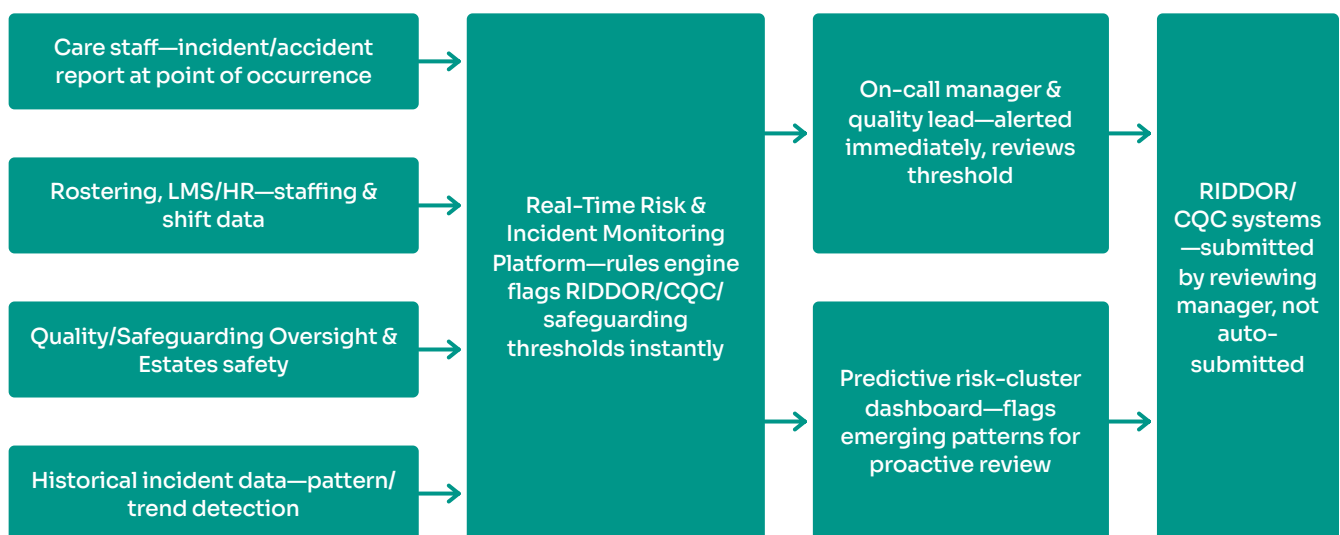
Interoperability

CURRENT STATE



Note: reportability is judged manually, notifications wait for the next reporting cycle, safeguarding referral runs as a separate manual pathway, and historical/staffing data aren't correlated—so emerging risk patterns and statutory deadlines are often missed.

FUTURE STATE



Note: the rules engine flags thresholds and alerts the on-call manager/quality lead instantly; that person reviews and submits to RIDDOR/CQC—submission is not automatic, given the legal significance of regulatory classification. Predictive analytics surfaces risk clusters for proactive review, not automatic intervention.

Social care Data Maturity Model

DEC proposes a four-tier Data Maturity Model to help providers consider how their use of data progresses from fragmented and manual, through consistent organisational reporting, to connected insight and carefully governed predictive use. It is an orientation tool, not an accreditation standard. A provider may sit at different levels across different domains — for example, optimised in workforce reporting but still siloed in estates or commissioner information.

TIER	SILOED	STANDARDISED	OPTIMISED	ACTUALISED
Strategy	Data is held in separate systems and manually compiled into spreadsheets. Reporting is inconsistent, with limited visibility across services and functions.	Core operational, quality, workforce and financial reports are consistently defined and available. KPIs provide greater visibility but are siloed by department and support day-to-day management decisions.	Data from multiple systems is connected to create trusted organisational insight. Managers can identify risks, trends and opportunities earlier and take proactive action.	Data is aggregated across the organisation and used to predict demand, improve outcomes and demonstrate impact. Information is shared safely across organisational boundaries to support better care and collaboration.
Value	Limited visibility and assurance. Decisions rely on local knowledge and manual reporting.	Consistent reporting improves oversight, accountability and operational management.	Trusted insight enables proactive decisions, performance improvement and risk reduction.	Data drives better outcomes, innovation and collaboration across the care ecosystem.
Governance	Data ownership is unclear. Local teams define, collect and interpret data in different ways. There is limited oversight of quality, access, retention or whether data is being used consistently.	Key data sets are identified, labelled and defined. Basic data standards, owners and access controls are agreed for priority areas. Reporting definitions are documented, but governance is still mostly departmental.	Data owners and stewards are in place for key organisational data sets. Data quality, definitions, access, retention and information governance are managed through agreed standards. Issues are visible and resolved through a clear governance route.	Data governance is embedded in organisational decision-making. Data is trusted, ethically used, securely shared and actively managed. Governance enables innovation, interoperability, assurance and safe data sharing across the wider care ecosystem.

A practical sequence for providers

Providers can use this maturity model alongside the requirements chapter through a simple sequence:

- Assess your organisation against the four maturity stages.
- Identify your priority use cases from the requirements.
- Establish the enabling data and systems those use cases require.
- Identify interoperability gaps.
- Apply the digital supply partner charter to existing and future suppliers.

- Build a prioritised digital improvement plan.
- Measure progress against defined outcomes.

Requirements by maturity level

The requirements across each domain sit at different points on this maturity model. Grouping them by tier can help providers see which capabilities are foundational and which build on them. For example, a requirement such as safe staffing insight depends on care needs, commissioned support, rostering, attendance, competency, training and recruitment compliance data all being in place first, which is why siloed requirements generally need to be established before later-tier capabilities can be built on top of them.

Siloed

- Accessible digital care records
- Consent/access
- Workforce compliance
- Cyber/data governance
- Data definitions
- Asset registers

Connect

- Commissioned/delivered/billed
- Recruitment-to-HRIS/payroll/rostering
- Incident/safeguarding reporting
- LA returns
- Staffing and competence
- Estates compliance

Optimised

- Supply/demand forecasting
- Referral/capacity forecasting
- Automated compliance
- Cross-functional quality dashboards
- Early warning indicators

Actualised

- Predictive risk
- Dynamic person-led support
- Outcomes-based commissioning

- Cross-sector data sharing
- Organisational drift detection

What the highest level of data maturity could deliver

A working age adult care provider that has achieved the actualised level in the Data Maturity Model will be able to access a huge amount of data from a range of different sources allowing it to analyse patterns and trends and massively increase its efficiency and effectiveness. Here are a few examples of the potential opportunities that could be unlocked:

- Integrating rosters with incident data to identify staff whose presence is correlated with reduced incidents allowing organisational learning about how best to support individuals.
 - Integrating video with daily care records and family feedback to assess how well individuals are being supported with their preferred form of communication, for example Makaton.
 - Immediate flagging of choke risk concerns where support plans and risk assessments aren't being followed.
 - Real time identification of breaches in CQC compliance.
 - Regular feedback on staff morale at individual and team level leading to reduce turnover.
 - Early identification of services at risk of a poor culture and possible abuse.
 - Providing evidence from daily records to demonstrate the requirement for additional 1:1 staffing for an individual.
 - Where a person's support needs increase requiring additional staffing, the roster system automatically notifies the CRM system which informs the social worker and automatically notifies the finance system which invoices accordingly.
-

Technical implications and interoperability: The Digital supply partner charter

Purpose

This Charter sets out the principles DEC wants to see from organisations that provide digital technology and services to care providers. It describes the partners with whom providers should be confident to work and invest: organisations that improve people's lives, support safe data movement, avoid unnecessary dependency and build sustainable relationships with the sector. Adoption of the Charter should be visible and capable of being tested through the accompanying Checklist.

1. People first — technology must improve people's lives

Digital supply partners should design with people who draw on and deliver care, supporting choice, control and independence. Solutions should be accessible, inclusive and straightforward to use, and should reduce unnecessary burden or monitoring rather than add to it.

2. Open APIs and full data access — data must move freely

Digital supply partners should provide clear, documented access to all core provider data through appropriate application programming interfaces and other agreed methods. Authorised systems should be able to read and, where safe and appropriate, write data. Providers should be able to extract their data at any time in a usable format. Integration access, documentation and charges should be transparent and proportionate.

3. Interoperability by default — systems must work together across care, health, housing and communities

Digital supply partners should align with recognised national standards, support a flexible “plug-in and plug-out” digital estate, and use shared identifiers such as the NHS number where lawful and appropriate. Proprietary formats should not be used to obstruct legitimate data sharing or portability.

4. Portability and fair exit — providers should retain choice

Digital supply partners should make exit, migration and data portability straightforward. Processes, responsibilities, formats and costs should be clear from the start of the relationship. Partners should compete through value, usability and outcomes rather than through avoidable dependency.

5. System leadership — DEC is changing how care works, not just digitising it

Digital supply partners should work collaboratively with providers, people supported and wider partners, contribute to shared learning and support transformation rather than digitising existing inefficiency. They should demonstrate a sustained commitment to adult social care, including an understanding of working-age adult services, learning disability and autism and should align product development with sector priorities and co-produced feedback.

Fair and transparent commercial models — sustainable partnerships

Digital supply partners should be open about pricing, implementation, integration, support, data access and exit costs. Commercial models should be transparent, proportionate and sustainable, recognising both the value delivered and the financial pressures facing care providers.

Providers are not simply buying systems. Together with digital supply partners, they are building a shared digital foundation for better lives, safer care and more sustainable organisations.

Provider-facing digital supply partner checklist

A provider checklist, for assessing Digital supply partners against this charter, is included at Appendix 1.

What needs to happen next

The roadmap identifies actions providers can take themselves and changes that require national or system leadership. The asks below separate the organisations involved so responsibility is clear. They are intended as a basis for engagement and co-design rather than an assumption that any body has already agreed to deliver them. The DEC Steering Group were very pleased with the positive engagement by CQC and hope this will be replicated by other stakeholders following the launch of this report. CQC has responded to our “asks” and their responses are highlighted below.

Taken together, these are the enabling conditions DEC considers necessary if digital excellence is to succeed at scale. The detailed wording will require engagement and co-design with the named organisations, but the underlying needs for national direction, aligned commissioning, interoperable data, workforce capability, proportionate assurance and fair digital supply partner practice should not be treated as optional if the model is to work beyond individual providers.

Department of Health and Social Care

- Set a clear national direction for digital excellence in adult social care that goes beyond record adoption and connects data standards, interoperability, workforce capability, commissioning and outcomes. [16] [17] [29]
- Lead a national review of the social care data model and the minimum information that should move safely between providers, commissioners, health partners and regulators, building on existing standards such as the Minimum Operational Data Standard (MODS) and the draft Reporting Minimum Data Specification (RMDS), rather than creating another isolated reporting system. [37] [38]
- Review how digital capability and its recurring costs are recognised in commissioning and cost-of-care approaches, including the investment needed for implementation, integration, cyber security, training and ongoing improvement.
- Develop, with the sector, the case for funding and cross-system benefits to HM Treasury, recognising that the organisation paying for digital change may not be the organisation receiving the financial return.

HM Treasury — through the DHSC business case

- Support investment models that recognise digital capability as infrastructure and allow benefits that accrue across health, local government and care providers to be considered together rather than in separate organisational budgets. [18]

NHS England

- Ensure adult social care providers and people drawing on care are represented in the design of shared care records, the Single Patient Record, interoperability standards and the wider analogue-to-digital shift. [11] [12] [13]
- Provide a clear national route for relevant social care data to be available to authorised health and care professionals without requiring separate local integrations for every provider and area (see Wider sector initiatives, p.14).

Integrated Care Boards and Neighbourhood Health partnerships

- Co-design local information-sharing, multidisciplinary working and investment arrangements with care providers from the outset, including how digital social care records and provider systems connect with neighbourhood services. [10]
- Agree shared outcomes and measures that capture value across organisational boundaries, including prevention, safer transitions, reduced duplication and experience of the person.

Local authorities

- Reduce variation in routine provider returns, compliance thresholds and data definitions, using common national templates where local variation is not necessary. [16] [23] [24]
- Create two-way digital processes for safeguarding, contract monitoring and changes in need so providers can see status, decisions and required actions rather than only submit information.
- Commission for outcomes and sustainable delivery, recognising the cost and capability required for providers to implement and maintain digital care.

Local Government Association and ADASS

- Convene local authorities to agree common templates, definitions and thresholds, share effective practice and support adoption. These bodies can coordinate and influence consistency even where they cannot mandate individual councils. [6] [7] [23] [24]

Care Quality Commission

- Co-design a proportionate approach to provider-held digital evidence, including how existing audit trails, dashboards and records can support Provider Information Returns and assessment without duplicate submissions. [15] [20]

CQC response: This sounds sensible in terms of co-design and while we are looking to improve our PIR in the short and medium term, the longer term strategic ambition would be for data from Digital Social Care Records (DSCR) to be directly used within the PIR and therefore reduce manual input and ensuring minimising of burden and effort.

- Provide clear and consistent expectations for digital records, data quality, information governance and the use of AI or predictive tools, retaining human judgement and challenge.

CQC response: We agree that clear expectations in this area are important. However, CQC is not a technical regulator, and our requirements are based on Regulations rather than the specific technologies used, whether records are maintained in paper or digital formats.

- Participate in testing any future early-warning approach before it is used for assurance or regulatory decision-making.

CQC response: I think this echoes the 10 Year plan for the NHS and the early warning system outlined on page 47 would suggest an approach to monitoring the quality of care at a service using information from DSCRs and elsewhere in a similar vein to what we've used internally minus DSCRs.

Ofsted

- For organisations supporting children, young people and people transitioning into adult services, work with CQC and local authorities to align expectations for digital evidence, consent, safeguarding and information transfer where possible. [25]

Skills for Care

- Embed practical digital, data and information-governance capability in workforce standards, leadership development and learning resources, including the confidence to question poor system design and use data responsibly. [21] [22] [30]

Department for Work and Pensions

- Ensure employment, skills and workforce programmes recognise the digital capability needs of adult social care and support people to develop transferable digital skills for care roles. [26]

Home Office and UK Visas and Immigration

- Maintain clear, stable and proportionate digital processes for sponsor compliance and right-to-work evidence, with requirements that can be integrated safely into provider workforce systems and audited without repeated manual re-entry. [27] [28]

Care providers

- Use the report to review maturity by domain, identify the problems that matter most, strengthen data ownership and governance and invest in staff and leadership confidence alongside technology.
- Use the digital supply partner charter and checklist in procurement, contracting and digital supply partner review, and require clear evidence of data access, interoperability, usability, security, portability and whole-life cost.
- Collaborate where competition is unnecessary, sharing learning, use cases and common requirements so smaller and less digitally mature organisations do not have to repeat the same mistakes.

Digital supply partners

- Adopt and evidence the digital supply partner charter.
- Provide documented, proportionate access to provider data, support recognised standards, portability and fair exit and avoid commercial models that make necessary integration or data access prohibitively expensive.
- Co-produce products with people drawing on support and the workforce, demonstrate usability in real care settings and publish a transparent roadmap showing how sector priorities are being addressed.

A shared responsibility

No single provider, commissioner, regulator or technology organisation can deliver this future state alone. The purpose of these asks is to create a shared direction with clear ownership: providers should improve what is within their control, while national and local partners remove the structural barriers that no individual provider can solve.

Appendices

Appendix 1: Digital supply partner checklist

Providers can use the checklist below when assessing Digital supply partners against the Digital supply partner charter (see Technical Implications and Interoperability).

CATEGORY	CRITERIA
Data and APIs	All core data available via API
	Read and write API access supported
	API documentation clear and usable
	Real-time or near real-time data exchange
	No excessive charges for integration
	Data export available in standard formats
Interoperability	Aligns to recognised standards
	Integrates with existing systems
	Evidence of live integrations
	Supports shared identifiers (e.g. NHS number)
	No proprietary data lock-in formats
Exit and portability	Clear exit process documented
	Full data export guaranteed
	Migration support available
	No punitive exit costs
Sector commitment	Track record in social care
	Experience with LD and autism providers
	Engagement with users and sector bodies
	Roadmap reflects social care priorities
Outcomes and care model	Captures what matters to the person
	Supports outcomes-based reporting
	Reduces duplication across systems

	Provides actionable insight
Workforce usability	Usable by frontline staff
	Reduces admin time
	Works in real care environments
	Training and onboarding is practical
Safety and governance	Meets UK GDPR and security standards
	Clear data use and consent model
	No unnecessary data collection
	Supports ethical use of technology
Commercial model	Transparent pricing
	No hidden costs
	Fair integration and exit terms
	Pricing aligned to value
Partnership and delivery	Evidence of co-production
	Responds to feedback
	Clear product direction
	Willingness to collaborate

Appendix 2: Glossary

This glossary covers the key acronyms and terms used throughout this report.

TERM	DEFINITION
Applicant tracking system	Software used to manage job applications and the recruitment pipeline, from advertising a vacancy through to hire.
Association of Directors of Adult Social Services (ADASS)	The national membership body for directors of adult social care in local authorities in England.
Baseline Personnel Security Standard (BPSS)	The UK Government's minimum pre-employment security-screening standard, sometimes required for roles handling sensitive information.
BS7858	A British Standard setting out the process for security screening of individuals working in a security environment, commonly used for pre-employment vetting.

Business intelligence	The tools and processes used to analyse organisational data and turn it into reports, dashboards, or insight for decision-making.
Care Certificate	A nationally recognised set of standards that health and social care workers are expected to meet as part of their induction.
Care Quality Commission (CQC)	The independent regulator of health and adult social care in England.
Certificate of Sponsorship (CoS)	A digital record issued by a licensed sponsor that a prospective migrant worker needs as part of a UK visa application.
Computer-aided facilities management (CAFM)	Software used to manage a property portfolio's assets, maintenance schedules, and reactive repairs.
Control of Substances Hazardous to Health (COSHH)	UK regulations requiring employers to control substances that can harm workers' health.
Customer relationship management (CRM) system	Software used to manage an organisation's interactions with prospective and current customers, commonly used here for referrals and occupancy pipelines.
Data Maturity Model	A framework (see the Social care Data Maturity Model chapter) describing how an organisation's use of data typically progresses from fragmented and manual through to fully integrated and predictive.
Data trust	A proposed model of shared data governance, in which multiple organisations agree common rules for how data is collected, accessed, and shared.
DEC (Digital Excellence in Care)	The group of care providers, national bodies and digital supply partners that produced this report.
Digital Care Hub	A national body supporting the adoption of digital technology across social care, and one of the national bodies collaborating on this report.
Digital social care record (DSCR)	An electronic record of a person's care and support, replacing paper-based care plans and daily notes.
Digital supply partner	An organisation providing digital systems, platforms, integration, data or technology services to care providers.
Disclosure and Barring Service (DBS)	The UK body that carries out criminal record checks (DBS checks) to help employers make safer recruitment decisions.
Dynamic Purchasing System (DPS)	A procurement tool used by commissioners to establish a list of approved suppliers that can bid for contracts as they arise.
Environmental, social and governance (ESG)	A framework used to describe and report an organisation's non-financial impact and conduct.
General Data Protection Regulation (GDPR)	The data protection law setting out how personal data must be collected, used, and protected.
Health and Safety Executive (HSE)	The UK regulator for workplace health and safety.
HR information system (HRIS)	Software used to manage employee records, such as personal details, role, location, and employment history.
Individual service fund (ISF)	An arrangement where a person's personal budget is held and managed by a provider on their behalf, alongside their own choices about how it's spent.

Infection prevention and control (IPC)	The practices and audits used to prevent the spread of infection within a care setting.
Information Commissioner's Office (ICO)	The UK's independent regulator for data protection and information rights, including data breach reporting.
Integrated Care Board (ICB)	The NHS body responsible for planning and commissioning health services in a local area.
Interoperability	The ability of different systems, run by different organisations or suppliers, to exchange and make use of each other's data.
Key performance indicator (KPI)	A measure used to track whether agreed contractual, quality, or operational targets are being met.
Learning management system (LMS)	Software used to deliver, track, and record staff training and competency.
Local authority	The council responsible for commissioning and overseeing adult social care within its area.
Medication administration record (MAR)	The record (paper or electronic) used to document that medication has been administered as prescribed.
My Good Life Plan	The workshop's term for a person-centred record of a person's own goals and aspirations.
NEWS (National Early Warning Score)	A clinical scoring system that combines several vital-sign measurements to flag early signs of a deteriorating patient; referenced in this report as a model for detecting organisational, rather than physiological, deterioration.
Office for National Statistics (ONS)	The UK's national statistical institute, a source of demographic and population data referenced in market intelligence.
Planned preventative maintenance (PPM)	Scheduled maintenance carried out to prevent equipment or building faults before they occur, as distinct from reactive (fault-driven) maintenance.
Positive behaviour support (PBS) plan	A person-centred plan setting out proactive strategies to support someone whose behaviour may challenge services, focused on understanding and meeting underlying needs.
PRN	From the Latin "pro re nata" (as the need arises); medication or support given as needed, rather than on a fixed schedule.
Provider Information Return (PIR)	Information a provider submits to the Care Quality Commission ahead of an inspection.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	UK regulations requiring certain workplace injuries, diseases, and dangerous occurrences to be reported to the Health and Safety Executive.
Right to work	Verification that a person is legally permitted to work in the UK, a mandatory pre-employment check.
Service level agreement (SLA)	An agreed standard for how quickly or to what standard a service (e.g. a contractor response) will be delivered.
VODG (Voluntary Organisations Disability Group)	A national membership body for voluntary sector organisations supporting disabled people, and one of the national bodies collaborating on this report.

Appendix 3: Reference material

-
- [1] Care England and Log my Care (2026), What Shapes Family Confidence in Care. Access via Care England White Papers: <https://smartdirectory.careengland.org.uk/white-papers>
-
- [2] Care England and Log my Care (2026), How Families Find and Choose Care. Access via Care England White Papers: <https://smartdirectory.careengland.org.uk/white-papers>
-
- [3] Care England and Sona (2026), Adult Social Care Insights: Workforce Stability, Digital Impact and Financial Confidence. Access via Care England White Papers: <https://smartdirectory.careengland.org.uk/white-papers>
-
- [4] Learning Disability England (July 2026), Digital Care Records Survey Feedback. Unpublished consultation report supplied to the DEC steering group.
-
- [5] The King's Fund (2026), Social Care 360. <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/social-care-360>
-
- [6] Association of Directors of Adult Social Services (2026), ADASS Spring Survey 2026. <https://www.adass.org.uk/wp-content/uploads/2026/07/ADASS-Spring-Survey-2026-Final-1-1.pdf>
-
- [7] Local Government Association (2026), Emergency government bailouts needed by a third of councils over the next three years — LGA survey. <https://www.local.gov.uk/about/news/emergency-government-bailouts-needed-third-councils-over-next-three-years-lga-survey>
-
- [8] Department of Health and Social Care (2026), Findings from the 2025 Adult Social Care Provider Technology Survey. <https://www.gov.uk/government/statistics/technology-use-in-adult-social-care-2025-survey-results/findings-from-the-2025-adult-social-care-provider-technology-survey>
-
- [9] Skills for Care (2026), The Size and Structure of the Adult Social Care Sector and Workforce in England. <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/Reports-and-visualisations/National-information/Size-and-structure-report.aspx>
-
- [10] NHS England (2025), Neighbourhood Health Guidelines 2025/26. <https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/>
-
- [11] NHS England, Digitising the Frontline. <https://www.england.nhs.uk/digitaltechnology/digitising-the-frontline/>
-
- [12] NHS England, Shared Care Records. <https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/shared-care-records/>
-
- [13] NHS England, The Single Patient Record. <https://www.england.nhs.uk/digitaltechnology/the-single-patient-record/>
-
- [14] Information Commissioner's Office, Data Sharing: a Code of Practice. <https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/data-sharing/data-sharing-a-code-of-practice/>
-
- [15] Care Quality Commission, Digital Record Systems: Achieving Good Outcomes for People Using Adult Social Care Services. <https://www.cqc.org.uk/guidance-regulation/adult-social-care/digital-record-systems-adult-social-care>
-
- [16] Department of Health and Social Care, Care Data Matters: a Roadmap for Better Adult Social Care Data. <https://www.gov.uk/government/publications/care-data-matters-a-roadmap-for-better-adult-social-care-data/care-data-matters-a-roadmap-for-better-adult-social-care-data>
-
- [17] Department of Health and Social Care (2025), Fit for the Future: 10 Year Health Plan for England. <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>
-

- [18] The Health Foundation (2025), Digitising the NHS and Adult Social Care: What Could It Cost? <https://www.health.org.uk/reports-and-analysis/analysis/digitising-the-nhs-and-adult-social-care-what-could-it-cost>
- [19] The Data Trusts Initiative. <https://datatrusts.uk/>
- [20] Care Quality Commission, Assessment Framework. <https://www.cqc.org.uk/guidance-regulation/providers/assessment/assessment-framework>
- [21] Skills for Care, Adult Social Care Digital Skills Framework. <https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Digital-technology-and-social-care/Digital-Skills-Framework.aspx>
- [22] Skills for Care, How Digital Ready Is Your Organisation? <https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Digital-technology-and-social-care/How-digital-ready-is-your-organisation.aspx>
- [23] Local Government Association, Implementing Digital Social Care Records. <https://www.local.gov.uk/our-support-partners-care-and-health/digital-transformation/implementing-digital-social-care>
- [24] Local Government Association, Implementing Digital Social Care Records: Case Studies. <https://www.local.gov.uk/case-studies/implementing-digital-social-care-records-case-studies>
- [25] Ofsted, Social Care Common Inspection Framework: Supported Accommodation for Looked-after Children and Care Leavers Aged 16 and 17. <https://www.gov.uk/government/publications/social-care-common-inspection-framework-sccif-supported-accommodation/social-care-common-inspection-framework-sccif-supported-accommodation-for-looked-after-children-and-care-leavers-aged-16-and-17>
- [26] Department for Work and Pensions and Skills England (2026), Sector Skills Needs Assessment — Health and Adult Social Care. <https://www.gov.uk/government/publications/skills-england-annual-skills-report-and-sectoral-skills-needs-assessments-2026/sector-skills-needs-assessment-health-and-adult-social-care>
- [27] Home Office, Right to Work Checks: an Employer's Guide. <https://www.gov.uk/government/publications/right-to-work-checks-employers-guide>
- [28] UK Visas and Immigration, Sponsorship: Guidance for Employers and Educators. <https://www.gov.uk/government/collections/sponsorship-information-for-employers-and-educators>
- [29] Department of Health and Social Care (2022), Data Saves Lives: Reshaping Health and Social Care with Data. <https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data>
- [30] Department of Health and Social Care, Care Workforce Pathway for Adult Social Care. <https://www.gov.uk/government/publications/care-workforce-pathway-for-adult-social-care>
- [31] Brightman Kinsey (2026), Stopping Organisational Drift — concept paper supplied to the DEC steering group.
- [32] Skills for Care (2025), The State of the Adult Social Care Sector and Workforce in England. <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/Reports-and-visualisations/National-information/The-State-of-report.aspx>
- [33] Care Quality Commission, Regulation 9: Person-centred care. <https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-9>
- [34] Skills for Care, Career and development. <https://www.skillsforcare.org.uk/Developing-your-workforce/Care-workforce-pathway/Career-and-development.aspx>
- [35] NHS England, Accessible Information Standard. <https://www.england.nhs.uk/accessible-information-standard/>
- [36] Professional Record Standards Body, About Me standard. <https://theprsb.org/standards/aboutme/>
- [37] Digitising Social Care, Minimum Operational Data Standard (MODS). <https://beta.digitisingsocialcare.co.uk/data-standards-social-care/minimum-operational-data-standard-mods>
- [38] NHS England, Reporting Minimum Data Specification (RMDS) (draft). <https://standards.nhs.uk/future-standards/reporting-minimum-data-specification-rmds-draft>

- [39]** UK Government, Health and Care Act 2022. <https://www.gov.uk/government/collections/health-and-care-act-2022>
-
- [40]** Department of Health and Social Care (2022), A plan for digital health and social care. <https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care>
-
- [41]** Department of Health and Social Care (2026), Adult social care provider statistics, England: quarterly update to August 2026. <https://www.gov.uk/government/statistics/adult-social-care-provider-statistics-england-quarterly-update-to-august-2026>
-
- [42]** UK Government, Data (Use and Access) Act 2025. <https://www.gov.uk/government/collections/data-use-and-access-act-2025>
-
- [43]** NHS England Digital, Adult social care data hub. <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/adult-social-care-data-hub>
-
- [44]** NHS England, Digital Medicines Programme. <https://www.england.nhs.uk/digitaltechnology/digital-medicines-programme/>
-
- [45]** Social Care Interoperability Platform (SCIP) webinar recording, March 2026. <https://www.youtube.com/watch?v=hIKOlwdxNb8>
-

October, 2026