The Role of Technology Enabled Care in a National Care Service

An Interim Briefing prepared for the Casey Commission by the TEC Services Association (TSA)









TSA™

The voice of technology enabled care

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About TSA and this briefing

The Technology Enabled Care Services Association (TSA) is the UK membership and standards body for technology enabled care (TEC). Our members include local authorities, NHS organisations, care and housing providers, and technology suppliers.

Through our standards, assurance, research and sector development work, we help create the conditions in which technology can contribute safely and effectively to better care and support.

The National Sector Support Programme

TSA's Sector Support Programme is a three-year, sponsor funded initiative designed to create the infrastructure needed for the safe, sustainable growth of Technology Enabled Care (TEC). The seven leading TEC organisations listed below have committed funding over three years, enabling TSA to undertake work that benefits the whole sector.

The programme aims to increase confidence and investment in TEC by addressing longstanding barriers to adoption, including gaps in evidence, inconsistent commissioning, limited awareness and difficulties implementing services at scale.

During 2026-27, the programme will deliver four key outputs:

- **Messaging:** An improved articulation of the value of TEC (contained within this briefing)
- **Evidence and insight:** An independent review of TEC evidence, an outcomes framework and the foundations of a national data resource to demonstrate the value of TEC.
- **Blueprint 2:** An updated practical blueprint for designing and implementing proactive and preventative TEC services, building on work with ADASS.
- **Commissioning Guide:** Practical guidance and tools to help local authorities commission effective, outcomes focused TEC services.

Together, these outputs will support better policy, stronger commissioning and wider adoption of TEC across health and social care.

Executive Summary

Technology Enabled Care should be designed into the National Care Service from the outset, not added later as an optional extra.

Technology Enabled Care (TEC) offers an opportunity to improve the quality of care and support people need to live independently for longer and it makes better use of scarce health and social care resources. Yet too often it remains a separate service, offered inconsistently and introduced only when people's needs have escalated. Whether people get TEC to support them depends on where they live.

The case for change is clear:

- **Better care for individuals and families.** TEC can help people remain safe, well and independent. It provides reassurance, supports choice and enables care to respond more closely to changing needs.
- **Earlier intervention rather than waiting for crisis.** Technology can help identify changes in people's circumstances before they become emergencies. The benefits depend on skilled staff, effective services and the capacity to respond, not technology alone.
- **Better use of scarce resources.** Well-designed TEC services can help professionals direct their time where it is most needed and reduce avoidable demand. There is growing evidence of financial benefits, although the longer term economic impact of preventative models needs further evaluation.
- **More joined-up care and better information.** TEC can connect services around the individual, and the information it generates can help local authorities, the NHS and care providers work together and act earlier, rather than operating separate systems and pathways.

What we are asking for:

The Commission has an opportunity to establish TEC as part of mainstream care rather than a separate technology offer. That requires a national expectation of fair access to TEC, wherever people live and whoever pays. TEC should be a routine consideration in assessment and care planning, incorporated into commissioned packages of care, and judged on outcomes for people and services, not financial savings alone.

Government should make TEC a core skill for the care workforce, so that everyone involved in care can recognise where it could help. It should make TEC visible in national data, so that variation in access and outcomes can be seen and addressed. A dedicated, time limited transformation fund would help Local Authorities and their partners redesign services to be more proactive and preventative, rather than simply replacing the technology they have. In the longer term, funding arrangements should share the costs and benefits of prevention across health and social care.

The evidence is sufficient to justify action now, although important questions remain about long term outcomes, costs and benefits at scale. TSA and its partners are developing the national evidence, commissioning guidance and practical tools needed to support implementation and strengthen future decisions.

The purpose of this briefing

This interim briefing has been prepared to inform the Casey Commission's consideration of the future of adult social care. It sets out TSA's position, on behalf of the TEC sector, on the role technology enabled care can play in improving independence, widening access to appropriate support and helping care services respond to growing demand. It identifies the barriers preventing wider adoption and proposes policy changes that could help overcome them.

The need is pressing. The population is ageing, more people are living with complex and long term conditions, and fewer working age people are available to provide care, paid or unpaid. Too often the system only responds once people reach crisis point. Our members and national stakeholder bodies such as ADASS and Skills for Care all recognise that technology is essential to prevention and to a sustainable workforce.

For the NHS, the shift from analogue to digital is rightly seen as central to its future. Government has invested billions in national NHS digital infrastructure, not as a replacement for workforce and funding but as an enabler. In social care, 'analogue to digital' has meant something much narrower: the switch from copper lines to digital connections (A2D). That switch was an essential safety change, but while some Local Authorities used it to rethink their service, others replaced the line and kept the same model of telecare delivery.

There is a wealth of innovation and best practice across the country, but it isn't spreading quickly enough. Older and disabled people who draw on care and support should benefit from the same advances in technology that we now expect across the NHS.

The definition for TEC used in this briefing is:

"Technology enabled care (TEC) is the use of technology, together with the services and interventions around it, to support adults' health, wellbeing, safety and independence."

1. How this briefing addresses the Casey Commission's remit

The proposals in this briefing are intended to support the Commission's consideration of how adult social care can become more preventative, sustainable and consistent, while improving the experience of people who draw on care and support. The table below shows how the role of technology enabled care connects to the wider questions of reform.

Area of the Commission's remit	How TEC contributes	What we are proposing
Prevention and early intervention	Identifies changing needs earlier, enabling timely support before problems escalate into crises or greater dependency.	Make TEC a routine consideration in assessment, care planning, review and preventative services.
Independence, choice and quality of life	Helps people remain safe and independent in their own homes, while supporting choice, confidence and social connection.	Establish a national expectation of fair access to TEC, with consistent standards but flexibility to meet individual needs.
A sustainable care system and workforce	Enables staff to focus their time where it adds most value and supports more effective responses to growing demand.	Develop workforce awareness, confidence and competence in TEC, supported by training and practical service design guidance.

Integration of health and social care	Connects information, monitoring and response services across home, community and health settings, supporting more joined-up care.	Embed TEC in National Care Service design, neighbourhood health services, hospital discharge, reablement and other shared pathways.
Funding, commissioning and financial sustainability	Can improve outcomes and use resources more effectively, but costs and benefits often fall to different organisations.	Support outcomes focused commissioning of complete TEC services and reform funding arrangements to recognise benefits across the system.
Fairness and consistency across England	Offers opportunities to reduce variation in access and support, rather than allowing local availability to depend on postcode.	Establish national expectations for access, quality and outcomes, while retaining local flexibility and individual choice.
Evidence, data and accountability	Generates evidence about outcomes, costs and service performance, as well as information that can help professionals identify changing care needs.	Develop common outcomes and evaluation standards, a national TEC data asset, and arrangements for making appropriate use of TEC generated information in care delivery.
Delivering practical reform	Offers existing services, technologies and implementation experience that can help translate national ambitions into operational change.	Build on TSA's Sector Support Programme, including Blueprint V2, the Guide to TEC Commissioning, Virtual Home V2 and the national evidence programme.

This mapping shows that TEC is not a separate technology initiative requiring its own place alongside wider reform. It is one of the practical means through which a National Care Service can deliver prevention, independence, better use of workforce capacity and more sustainable care.

2. How this briefing was developed

This briefing draws on an independent assessment of the available evidence by the Social Care Institute for Excellence (SCIE), alongside TSA's sector knowledge and engagement with commissioners, providers and other stakeholders. We distinguish between the evidence, our interpretation of its implications and the recommendations we are making to government. It builds on the initial evidence and programme overview presented to the Commission and DHSC in October 2026. It develops the key messages shared at that meeting into proposals for national policy and action, while recognising the evidence gaps that our continuing Sector Support Programme is designed to address.

3. What this briefing does and does not contain

This briefing sets out our position and recommendations and the evidence they rest on, including its strengths and limitations. It is not a fully costed national business case for TEC. The evidence needed to establish the economic benefits consistently across different populations and care models is not yet sufficiently developed.

We are a few months into a national programme to strengthen that evidence and to remove the barriers that the sector can address itself. In the full version of this briefing paper due to be published in March 2027, we intend to include economic analysis from Colligo Labs to address some known gaps and a more complete picture of the state of the sector, adding together data from multiple TSA members to show the scale and scope of TEC in the UK. Much of the evidence and case studies shared to date refer to the support of older people only, so the full briefing paper will also set out the role that TEC can play in the lives of working age adults.

Colligo Labs

4. We welcome the Commission's guidance

We see this interim briefing as the beginning of a continuing dialogue, and we want to work in partnership with the Commission, DHSC and NHS England to identify where technology can be built into the reforms. In particular, we would welcome the Commission's views on:

1	**Policy priorities**: Which of our recommendations would be most useful to the Commission's work?
2	**Evidence:** Where is the existing evidence sufficient to support recommendations, and where is further evidence required?
3	**Further analysis:** What additional economic, operational or population-level analysis would most help inform the Commission's conclusions?

Thelma's story: two possible futures for care

Illustrative scenario, not a documented case study.



Thelma is 85 and lives alone in the home she has occupied for more than 40 years. She has always been independent and takes pride in looking after herself. She enjoys spending time in her garden, visiting friends and being part of her local community.

Her daughter lives nearby and visits regularly, but she also has a job and children of her own. She helps Thelma with shopping and some household tasks, while Thelma continues to manage most aspects of her daily life.

Recently, things have started to change. Thelma is becoming frailer, moving around less confidently and finding some everyday activities more difficult. Her daughter has noticed that she is going out less often and is increasingly concerned about her safety when nobody is around.

Both want Thelma to remain safe, well and independent in her own home for as long as possible. But what happens next could be very different depending on how care is organised and whether technology is used effectively.

Thelma's story is far from unusual

- **1 in 3+: People** over 65 experience a fall each year. Source: NHS England. This figure relates to falls generally, not specifically falls in the home.
- **3.3 million**: People aged 65 and over lived alone in England and Wales in 2021. Source: ONS, Census 2021.
- **5.8 million**: People provide unpaid care across the UK. Source: Carers UK, 2025.
- **52%**: Of carers surveyed said they were providing more hours of care than a year earlier. Source: Carers UK, State of Caring 2025 (survey respondents, not all carers).

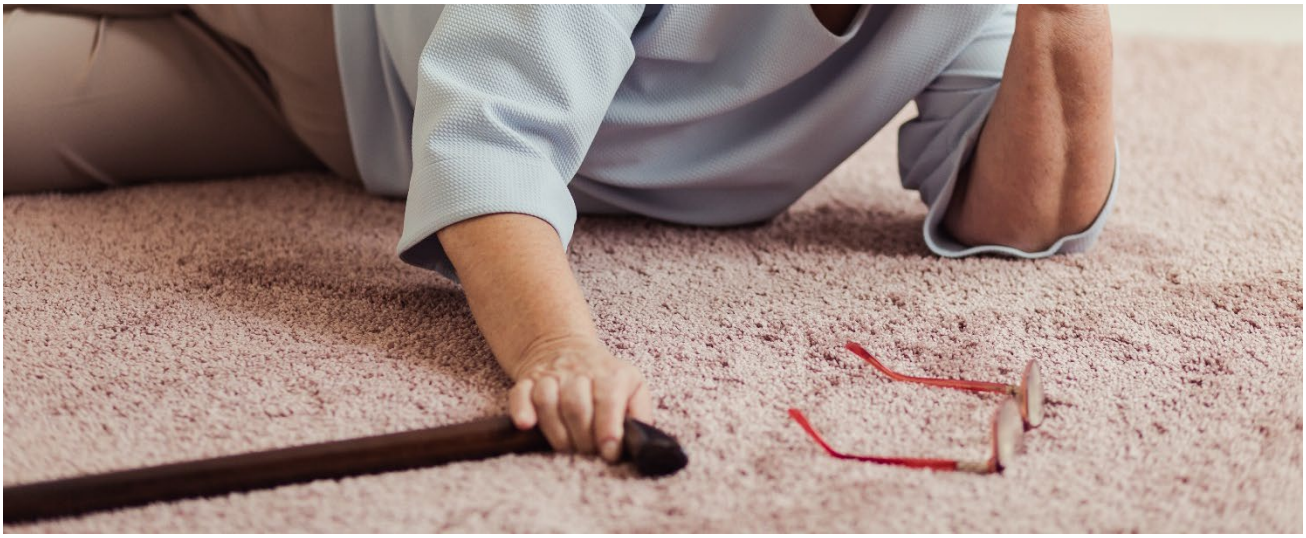
Falls can reduce confidence, mobility and independence even without serious injury. These figures illustrate how common the circumstances around Thelma's story are, they are not evidence that TEC alone prevents these outcomes.

Without joined up, technology enabled care

Thelma continues living alone, gradually becoming less confident and less active. Her daughter begins visiting more frequently and calling during the day to check that everything is all right. Balancing these responsibilities with work and family life becomes increasingly difficult.

There is no systematic way of recognising the gradual changes in Thelma's circumstances or bringing together information that might indicate she needs additional support. Her daughter mentions her concerns to the GP. A referral may be made to adult social care, but health and care professionals hold different information and may assess Thelma's needs separately. Nobody necessarily has a complete picture of how her daily life is changing.

Eventually, Thelma has a fall at home. Unable to get up, she waits until her daughter arrives and calls for help. Thelma is taken to hospital for assessment. Although she has no serious injury, the experience leaves her anxious about falling again. She becomes less mobile, stops going out independently and begins relying more heavily on her daughter.



When Thelma returns home, additional support is arranged. Different professionals become involved, but their interventions are not necessarily coordinated. Her daughter finds herself managing appointments, explaining Thelma's circumstances repeatedly and trying to make sure everyone understands what support is already in place.

The system has responded to Thelma's immediate needs, but largely after a crisis. Health and social care professionals are now providing more intensive support, while opportunities to recognise her increasing frailty and intervene earlier may have been missed. Most importantly, Thelma has lost some of the confidence and independence that mattered so much to her.

With joined up, technology enabled neighbourhood care

Thelma still lives alone, and her circumstances begin to change in exactly the same way. But this time, the local care system is organised to recognise and respond to those changes earlier.

During an assessment of Thelma's needs, a practitioner discusses what matters most to her. She wants to remain in her own home, continue seeing her friends and feel confident going about her daily life. She values her daughter's support but does not want her to spend every spare moment worrying about her.

Together, they consider how technology might help. Thelma agrees to a combination of unobtrusive monitoring and a personal alarm, chosen to suit her circumstances. She understands what information will be collected, who will see it and what will happen if she needs assistance. The technology is straightforward to use and does not interfere with her daily routines.

The service is designed to do more than respond to emergencies. Information about Thelma's normal patterns of activity can help identify changes that might otherwise go unnoticed between visits. Importantly, there are clear arrangements for reviewing that information and deciding when somebody should act.

Over several weeks, changes in Thelma's activity suggest that she is moving around less and spending more time at home. A trained member of the TEC service recognises that this may be significant and contacts Thelma to understand what is happening. Thelma explains that she has been feeling unsteady and has stopped going into the garden because she is frightened of falling.

Because the TEC service is connected to the local neighbourhood care team, this information can be shared appropriately with the professionals involved in her care. The team does not need to start from scratch or wait for Thelma to reach a crisis before offering support.



A practitioner visits Thelma and, with her agreement, brings together the appropriate professionals to consider what might help. They review her medication, mobility, home environment and wider circumstances. Her daughter contributes her observations, but Thelma remains at the centre of the decisions.

Together, they agree a plan. A physiotherapist helps Thelma rebuild her strength and confidence. An occupational therapist recommends some small changes around the home. Her care plan is updated, and the TEC service continues to provide reassurance and information about changes in her daily activity.

The arrangements are not dependent on one particularly enthusiastic professional or a short term project. The local authority, NHS and care providers have agreed how information will be shared, who is responsible for responding and how Thelma's support will be reviewed as her needs change.

If Thelma becomes unwell or has a fall, there is an established route for getting appropriate help. Where clinically suitable, the neighbourhood team can arrange assessment, treatment or rehabilitation at home. If hospital care is necessary, information about her circumstances can support her return home and recovery.

As Thelma regains confidence, her support can be adjusted. She begins spending time in her garden again and feels able to visit friends. Her daughter has greater reassurance that help is available when needed, without having to organise every aspect of her mother's care.

Thelma may still need more support as she grows older. Technology cannot prevent every illness or fall. But her care is no longer organised primarily around responding to emergencies. It is designed to recognise changing needs, intervene where appropriate and help her maintain the independence that matters to her.

For Thelma, the outcome is not simply that she has avoided a hospital visit or required fewer care hours. It is that she has been able to continue living safely, well and independently in her own home, on her own terms.

For health and social care, the opportunity is to make better use of scarce professional capacity: recognising needs earlier, directing the right expertise to the right people and avoiding unnecessary escalation where possible.

What Thelma's story tells us

The difference between these two futures is not simply the presence of technology. In the second scenario, technology helps make changes in Thelma's circumstances visible, potentially earlier than they would otherwise have been recognised. But that information only becomes valuable because somebody understands it, has responsibility for acting on it and can arrange an appropriate response.

It also depends on physiotherapy, occupational therapy and other community services having the capacity to respond. As we set out later in this briefing, that capacity cannot be assumed. Technology makes earlier intervention possible. Workforce capability, joined up services and effective response arrangements turn that possibility into better care. Thelma does not need to understand how neighbourhood health is organised, which organisation commissions her support or which technology is being used. She needs the right people to recognise when her circumstances change and help her continue living the life she wants.

That is the opportunity for technology enabled care: better outcomes for individuals, greater confidence for families and better use of scarce health and social care resources.



TSA's position

1. TEC is already part of everyday care for millions of people

Technology enabled care should be treated as part of the core infrastructure of adult social care. An estimated two million people in the UK are supported by technology enabled care, making it one of the most widely used forms of care and support, and an essential part of any sustainable model of adult social care.

TEC can play a role at every stage of the care journey: supporting independence and wellbeing, enabling monitoring and early intervention, and ensuring a rapid response when it's needed. It supports older people, working-age disabled adults, people with learning disabilities, and those with mental health needs.

It also supports many people providing unpaid care. For many families it is what makes caring manageable: knowing someone will respond if their relative needs help, being able to keep working, and not having to worry throughout the day.

We believe millions more people, and the families who support them, could benefit from technology that helps them live safely, well and independent at home for longer and stops their needs escalating.

2. TEC enables better care outcomes, better use of scarce resources and delivers value for money

The strongest evidence for TEC is in supporting independence, improving safety and enabling more effective use of care resources. There is also credible evidence that TEC can help identify changing needs earlier and support timely intervention, creating opportunities to prevent or delay escalation. However, the evidence that these interventions consistently deliver longer term preventative outcomes and measurable cost savings remains less developed.

On falls, for example, which cost the NHS £2.3 billion annually, numerous projects have now shown that TEC can reduce ambulance callouts, hospital admissions and 'long lies'. Wider monitoring helps too: spotting the early signs of an infection, or reduced daily activity, both common predictor of falls, can allow earlier intervention.

Available 24/7, TEC can provide reassurance and, where services are redesigned appropriately, allow care workers to spend more time providing support that requires human judgement and personal interaction. It can also help people stay connected, reducing social isolation and loneliness. How TEC is implemented matters: it should enhance rather than replace human contact, ensuring that greater efficiency does not come at the expense of people's wellbeing.

AI and predictive analytics are extending what TEC can do: spotting subtle changes in someone's routine, flagging rising risk of falls or deterioration, and helping responders prioritise. AI is also starting to reduce the time staff spend on records and notes. But it raises the stakes on the conditions set out below: good-quality data, clear responsibility for acting on a prediction, transparency for the person, and safeguards against bias. Used within a well-designed service, AI can help staff focus where they are most needed.

It is hard to show the full scale of the opportunity. Data is not routinely tracked across health and social care and there are no consistent outcome measures or baselines. Local authorities and providers struggle to build TEC into care pathways, or to measure its impact on other services, including the NHS. That is a case for consistent measurement and evaluation, and not a reason to wait.

What we could consider though is just how many opportunities there are to 'prescribe' TEC to support people earlier:

- Every year in England, local authorities receive over two million requests for adult social care support from approximately 1.4 million people (all figures DHSC 2024/25).
- Around 0.8 million requests result in no further local authority action, often following advice or signposting. Others lead to short term interventions or ongoing care.
- Alongside the more than 600,000 people who receive new assessments, over 700,000 reviews of existing care plans take place annually.
- Each of these interactions represents an opportunity to consider whether technology could help people maintain independence, prevent escalating needs or improve existing care arrangements.
- The opportunity is not simply to introduce TEC into more care plans. It is to make TEC a routine consideration throughout the adult social care journey.

TEC has the potential to help people remain independent, identify risks earlier and make better use of health and care resources. However, the financial case must consider the cost of the complete service, including monitoring and response, and distinguish between savings that can be realised and costs that may be avoided or delayed. The opportunity is to invest earlier, measure outcomes consistently and understand the value created across the whole health and care system.

3. We know what good TEC looks like, but it is not yet the norm

The evidence reviewed by SCIE identified six common conditions for success:

- the right fit for the person chosen, not imposed, with their trust and involvement, protecting their privacy, and adding to human care rather than replacing it
- a skilled and confident workforce, with time to use TEC well
- clear responsibility for responding when technology flags a change
- reliable, connected infrastructure and data
- leadership and commissioning that treat TEC as service change, not procurement
- long term ownership, so services adapt as needs change and don't fall away when funding ends

Fair access must run through all six, or TEC will widen inequalities rather than reduce them. That means designing services for people with limited digital confidence, connectivity or money, and offering help to use the service, not just the devices. It also means respecting choice: TEC should be offered, never imposed, and people who decline it should not receive a lesser service.

Annex E sets out eight of the most common ways proactive and preventative TEC is already being used. They range from the social care front door, where TEC helps people with lower level needs to support themselves and avoid needs escalating, through assessment and reassessment, reablement and hospital discharge, remote care and long term care at home, to falls prevention and response, wellbeing calls and medication support. Each is illustrated with examples from Local Authorities already using it, including Essex, Sutton, Stockton-on-Tees and Mole Valley. We are also aware that the Government will shortly publish details of the eight projects funded through the Adult Social Care Technology Fund. These will add to the growing evidence base on what good TEC looks like, and we would welcome the opportunity to draw on them in our fuller submission.

4. What people get depends on where they live

In many parts of the country, the offer is still limited to reactive telecare, responding to an alarm or incident rather than routinely identifying changing needs before a crisis occurs. Proactive and preventative models are developing, but their adoption remains uneven.

What people are offered, who gets it, how they get it and what it costs all vary widely between postcodes. It can depend on how familiar the practitioner they speak to is with TEC, or whether their housing provider offers it. Some Local Authorities provide TEC free, while others charge up to £12 a week. Some variation reflects local innovation, but much of it is unwarranted, and because TEC is not recorded in national data, most of it goes unseen.

Local Authorities already have a duty under the Care Act to prevent, reduce and delay needs. Yet in many areas TEC is still tied to eligibility thresholds, so people are only offered it once their needs are significant. With 1.4 million requests for adult social care support resulting in no further local authority action last year, every one of those contacts could have been a chance to consider TEC earlier, including for people who will not qualify for Local Authority-funded care. Instead, people too often have to reach crisis before they can get the support that might have prevented it.

People who pay for themselves often have little help to choose and few assurances about quality. Any advice they get is all too often focused on the use of specific technologies rather than the full process that is at the heart of TEC deployment. As part of Local Authorities' duty to provide information and advice to everyone, this could include more routinely helping people choose TEC with confidence and know what good looks like. We believe that fair access to TEC should be part of what everyone can expect from adult social care, wherever they live and whoever pays.

5. Workforce capability is a critical enabler

We note that the Minister of State for Social Care, Alison McGovern, has recognised the importance of putting technology in the hands of a skilled workforce to improve outcomes for people who draw on care (Source Hansard). We agree with this position and believe that workforce development is essential to increasing the adoption of technology enabled care.

TEC will only become a routine part of adult social care when the people assessing needs, developing care plans and delivering support have the awareness, confidence and competence to recognise where it could improve outcomes. The availability of technology does not, in itself, create demand or ensure that it is used appropriately.

Today, the extent to which TEC is considered can depend on the knowledge and confidence of individual practitioners. Where staff understand the options available and how TEC can support independence, safety and wellbeing, they are better equipped to discuss these with people drawing on care and incorporate appropriate solutions into care plans. Where that understanding is missing, opportunities may be overlooked, contributing to variation in access between local authorities and individual practitioners.

Workforce development therefore needs to extend beyond specialist TEC teams. Social workers, occupational therapists, care assessors, care coordinators and others involved in assessment, referral, care planning and review all have a potential role. Their training should focus not simply on understanding available technologies, but on recognising appropriate opportunities, discussing choices with individuals, understanding how the technology fits within wider care arrangements and knowing what response or intervention is required when technology identifies a need, namely the full TEC deployment.

There is also a distinct requirement to develop the capabilities of those delivering TEC enabled services. Monitoring information, identifying changes in circumstances and responding appropriately require clear responsibilities, competent staff and effective links with wider health and social care services. Without these arrangements, the potential benefits of proactive and preventative TEC will not be realised.

TSA is already investing in workforce development through its Virtual Home training programme, which provides a practical introduction to TEC and its application in care. The next phase of this work provides an opportunity to extend awareness and capability across the wider workforce, supporting more consistent consideration of TEC within everyday practice.

The opportunity is to make TEC a normal consideration in assessment and care planning, rather than something dependent on individual enthusiasm or specialist knowledge. Workforce development should therefore be treated as an essential part of implementing future care models, not as an optional activity once new technology has been introduced

Consistent barriers are stopping good TEC models from scaling

So why hasn't good practice spread? Data from LG Inform shows that investment in TEC is flat or falling in places while demand rises, and despite national policy pointing firmly towards prevention and care at home. When we asked Local Authority finance leaders why, they were clear: they are under severe financial pressure, the prevention funding paradox has not been solved, and the evidence is not yet strong enough to justify the risk. Four barriers stand out.

- **The organisation that pays is not the one that benefits.** Local Authorities fund TEC, while much of the saving, in avoided ambulance callouts, A&E attendances and hospital stays, falls to the NHS. The case can be compelling for the system as a whole and still hard to make for a single Local Authority budget. Some of the value falls outside health and care altogether, for example when unpaid carers are able to stay in work. The case needs to be made, and funded, on a whole-system view.
- **Short term funding traps services in pilots.** Too many Local Authorities are paying to prove the same things again, because pilots rarely become routine services.
- **The risk falls on whoever goes first.** Projected savings are often taken out of budgets before they have been made. Local Authorities are understandably reluctant to be first when savings are uncertain and the benefits of prevention may land elsewhere.

- **Capacity is not in the right place to act on early warnings.** Technology can spot that someone's needs are changing, but services under pressure often have no one with the time or the role to respond. Insight without action isn't prevention.

Too often Local Authorities reprocure a technology service, rather than redesign the service around it. Redesign requires practical help: mapping current pathways and processes, changes to commissioning practice, a culture that allows teams to test and learn, and support to run old and new models side by side while they change. These are system problems, not local failings, and only national action can remove them.

6. TEC can provide valuable intelligence about changing care needs

Technology enabled care has a role beyond the immediate support it provides to individuals. Monitoring services can generate information about people's daily routines, changing circumstances and emerging needs. When this information is interpreted by trained staff and connected to appropriate care and support, it can help professionals make better decisions and intervene earlier.

There is evidence of this potential in practice. Activity monitoring can inform assessments and care planning, while other monitoring services have demonstrated how information can be used to change working practices and target staff time. However, the wider benefits of using this information for predictive prevention and population-level planning have not yet been established consistently at scale.

For a future National Care Service, the opportunity is to make appropriate use of this intelligence alongside other health and social care information. This could help neighbourhood teams recognise changing needs, plan support and understand which interventions work best. Realising that opportunity will require common standards, secure information sharing, clear responsibilities and sufficient workforce capacity to act on the information generated.

7. The National Care Service is the opportunity to build TEC in

The Prime Minister has committed to a National Care Service that 'starts in the home'. TEC needs to be part of its design from the start, or it will remain a bolt-on for another decade.

Government has invested heavily in digital infrastructure for hospitals and GP practices, as an enabler for the workforce. But the place where most care happens, the home, has not yet been considered as part of that infrastructure. TEC is the bridge, and each of the 10-Year Health Plan's shifts depends on it. Care will only move from hospital to community when professionals are confident that people are safe at home, and that someone will know quickly if that changes.

Effective prevention needs early signals of changing need. Linked with health and care records, data from TEC can help neighbourhood teams identify people and groups at rising risk and target support before a crisis. The move from analogue to digital is incomplete if it stops at the NHS's door.

In practice, that means building TEC into neighbourhood health models, into hospital discharge and reablement, and as a core part of the new Modern Service Framework for frailty. It means making good TEC a routine part of how care is assessed, planned and delivered, with a national standard for what people can expect.

Today, technology in people's homes is commissioned in parallel. The NHS commissions remote monitoring, telehealth and virtual wards, Local Authorities commission TEC, and homecare providers and housing providers may run their own services. An individual or household can have multiple devices and monitoring or response services that run separately. This is not only confusing for people, but also deeply inefficient. For neighbourhood health to be person-centred, technology in

the home needs to work as one connected system linking people, their homes, families, professionals and services, with shared information and clear responsibility for who acts when something changes.

We need common standards for quality and interoperability to allow information to flow between TEC services, care records and the Single Patient Record. Common standards also underpin public trust: people and families need to know that services are safe, reliable and handle their data well. They should build on existing quality frameworks rather than start from scratch. Resilience needs planning in from the start, so that if a service or supplier fails, no one is left without support.

8. We can't afford to wait

The sector is already acting. Through TSA's National Sector Support programme, we and our members are working to build the evidence base and the tools Local Authorities need to move from reactive telecare to proactive, preventative support.

Evidence gaps remain, but they should shape how we evaluate, not whether we act. TEC should be judged on what it does for people, not on cashable savings alone, and every new deployment should add to a shared evidence base so no area has to learn the same things again.

There are practical changes government could make now that would benefit millions of people before the end of this Parliament. Every year of delay means more people reaching crisis who could have been supported earlier. We set these out below.

Our recommendations fall into three areas: what we want the Casey Commission to recommend, what government can act on now, and the longer term reforms needed to make TEC a routine part of care and support.

What we are asking the Casey Commission review to include

1. Set a national expectation of fair access to TEC

Why: The support that people are offered should not depend on their postcode. With 400,000 people waiting for an assessment, for care to start or for a review, every contact is a chance to offer TEC earlier and help people remain independent for longer.

The Commission should: Recommend that government establishes a national standard for what people can expect from TEC, wherever they live and whoever pays. It should signal clearly to local authorities that access to TEC should not depend on eligibility for Local Authority funded care, and that anyone should be able to find out what support is available through their Local Authority. This should be underpinned by a national commissioning framework with common outcomes, a clear Theory of Change and expectations for quality, response capability, interoperability, supplier viability and sustainability. The framework should support Local Authorities to commission complete, outcomes focused services rather than technology alone.

The sector will: Publish an updated Guide to TEC Commissioning, helping Local Authorities move to commissioning complete, outcomes focused services. We will work with DHSC on the minimum standards, drawing on our experience of quality assurance.

2. Make consideration of TEC routine in assessment, care planning and care pathways

Why: TEC works when it is built in, not bolted on. DHSC already expects Local Authorities to consider the best use of care technology in preventative services. The National Care Service should make that routine.

The Commission should: Recommend that TEC becomes a routine consideration within assessment, care planning and review, and is included as an integral part of commissioned packages of care wherever it can help meet an individual's needs and preferences. TEC should not be treated as a separate add-on or equipment service, but as part of the care and support that commissioners fund and providers deliver. This principle should also apply to discharge, reablement, falls and frailty pathways, with appropriate joint commissioning across health and social care. It should be reflected in the National Care Service design principles, neighbourhood health guidance and Modern Service Frameworks.

The sector will: In partnership with ADASS, TSA will publish an updated Blueprint for proactive and preventative TEC services in November 2026, with practical tools and templates to help commissioners and providers redesign services. During the first half of 2027, we will bring local systems together to explore how TEC can be integrated into neighbourhood working and share the learning across the sector.

3. Judge TEC on outcomes for people and services, not financial savings alone

Why: The evidence reviewed by SCIE shows that TEC can create value in three distinct but connected ways: better outcomes and experiences for people and their families, better use of scarce workforce and service capacity, and better use of financial resources. Financial savings matter, but they are not the only measure of success. Greater independence, improved wellbeing and better experiences of care have value in their own right, even where they do not produce an immediate cashable saving.

The Commission should: Recommend that the contribution of TEC to future care models is assessed against all three forms of value, rather than financial savings alone. National policy, commissioning and evaluation should recognise outcomes for people, workforce and service capacity, alongside costs and financial returns. The strength of evidence should be made clear for each, distinguishing demonstrated benefits from those requiring further evaluation.

The sector will: Develop and promote a consistent approach to measuring TEC outcomes, building on TSA's Outcomes Framework and the Theory of Change developed with Colligo Labs. Through our Sector Support Programme, we will work with commissioners, providers and research partners to strengthen the evidence across all three forms of value and support more consistent evaluation of TEC enabled services.

What we are asking Government to act on now

4. Make TEC a core skill for the care workforce, and support carers

Why: Practitioners decide whether TEC is considered at all yet, according to the APPG for Assistive and Accessible Technology only 39% of care staff had any IT, digital or data training in 2024/25, and most of that was on GDPR. And according to the ADASS Spring Survey only 5–10% of unpaid carers receive any Local Authority support, while TEC can help many more keep caring alongside work and family.

Government should: Build on the new care technologist role category in Care Workforce Pathway by making TEC capability a core competence in social work and occupational therapy training. Support Local Authorities and providers to develop care technologist roles locally. Support unpaid carers to use TEC with confidence, as part of Local Authorities' expected increase in carer support.

The sector will: Expand TSA's workforce development programme, including the next version of Virtual Home, funded by Skills for Care and scheduled for completion in April 2027. Following completion of the updated Virtual Home, we will work with national workforce partners to develop a plan for increasing TEC awareness, confidence and competence among those involved in assessment, care planning and support.

5. Make TEC visible in national data

Why: You cannot fix variation you cannot see. DHSC has acknowledged that there is currently limited data on the telecare market, and that it remains difficult to measure the impact of Local Authorities' preventative services. As AI and predictive tools come into common use, the quality and linkage of this data will become even more important. TEC services also generate information about people's changing needs, creating opportunities for earlier intervention and more personalised care.

Government should: Record TEC usage in national adult social care data collection: what is offered, to whom and at what cost. Link it with LA, provider and community systems, and make it available to research environments. Ensure that the development of national data standards also considers how information generated by TEC services can be securely shared and used by care professionals to support earlier intervention.

The sector will: Develop a national TEC data asset that brings together consistent, comparable information from commissioners, service providers and technology suppliers on the scale, reach, use, costs and outcomes of TEC services. This will establish a clearer picture of the sector today, enable progress to be tracked over time and strengthen the evidence of TEC's contribution to independence, prevention and the effective use of care resources.

Through its Sector Support Programme, TSA is developing a State of the Sector overview as the foundation for this work, while the Hartree Centre is exploring the technical requirements for a national database. Together, these initiatives will help identify which approaches deliver the greatest benefits, for whom and under what circumstances, and support longer term evaluation of proactive and preventative TEC.

6. Enable investment in service transformation

Why: Moving from reactive telecare towards more proactive and preventative models requires investment in service redesign, workforce development and new ways of working, not simply new technology. Local Authorities face significant financial pressures and cannot always justify the upfront costs and risks, particularly where the benefits may be realised elsewhere in the health and care system. Short term funding has also encouraged repeated pilots rather than sustainable service transformation.

The previous government's commitment of at least £150 million to digitising adult social care provides a useful precedent. This investment supported the adoption of digital social care records and wider digital capability across the sector. A similar commitment is now needed to help Local Authorities move beyond replacing existing technology and redesign services around proactive and preventative care.

Government should: Establish a dedicated, time limited national transformation fund to support local authorities, working with NHS and care partners, to redesign services around proactive and preventative TEC. Funding should support service redesign, workforce development, commissioning capability, implementation and evaluation, rather than simply purchasing technology.

The fund should draw on lessons from the Digitising Social Care programme, with clear expectations for outcomes, independent evaluation and a route from successful implementation to sustained delivery. Existing funding arrangements can support individual projects or technology adoption, but they do not consistently provide the transitional investment needed to redesign

services, develop workforce capability and sustain new operating models while existing services continue.

International example from Spain

In October 2026, Spain introduced legislation establishing telecare as a legal entitlement for people formally recognised as needing care and support, regardless of their assessed level of dependency. The legislation defines telecare as a personalised, continuous service that combines technology and human support to promote independence, prevent risks and support community living. Although its implementation and outcomes remain to be demonstrated, Spain provides an example of how national policy can establish more consistent access to TEC as part of mainstream care provision.

The sector will: Develop a consistent approach to evaluation, including common outcome measures and methods for assessing costs, benefits and their distribution across health and social care. Through TSA's Sector Support Programme, we will work with commissioners, providers and research partners to build the evidence, share practical learning and identify the conditions under which successful models can be sustained and scaled.

What will make the biggest difference in the long term

7. Share the costs and benefits of prevention across health and social care

Why: Prevention should not be blocked because the organisation that pays for an intervention is not the one that financially benefits. TEC can improve independence, reduce demand for care and support more effective use of NHS and local authority resources, but the costs and benefits frequently fall across different organisations and budgets. Current funding arrangements can discourage investment even where the wider system stands to benefit.

Government should: As part of longer term National Care Service reform, develop funding arrangements that enable investment in preventative care around the needs of the individual, rather than the boundaries between organisations. This should include mechanisms for sharing the costs, risks and benefits of TEC enabled care across local authorities, the NHS and other relevant partners, with accountability for outcomes and sustained delivery.

In the shorter term, encourage joint commissioning and investment through neighbourhood health arrangements, and clarify how existing funding mechanisms, including the Better Care Fund and Disabled Facilities Grant, can appropriately support TEC enabled care and prevention. Local government reorganisation and devolution are an opportunity to go further, bringing adult social care, housing and health budgets closer together with clearer local accountability.

Funding arrangements should also enable local systems to retain and reinvest demonstrable savings from preventative interventions, creating a stronger incentive to measure benefits and sustain successful approaches.

The sector will: Work with commissioners, providers and national partners to map how costs and benefits flow through representative TEC pathways, identify where current funding arrangements discourage investment, and develop practical examples of shared investment and accountability. We will use this work to inform proposals for sustainable funding models that support preventative care.

TSA Sector Support Programme: Delivery Commitments 2026–2027

Deliverable	Target date	Intended contribution
Blueprint V2	November 2026	Practical guidance for designing and delivering proactive and preventative TEC services.
Local Authority Briefing	December 2026	Rewrites and restructures the Commission briefing for Local Authority senior leaders and Finance Officers.
Virtual Home V2	April 2027	Improve workforce awareness, confidence and competence in identifying and recommending TEC.
Guide to TEC Commissioning	March 2027 (at ITEC, TSA's annual conference)	Help Local Authorities commission complete, outcomes focused TEC services as an integral part of care.
Final Report for Casey Commission	ITEC, March 2027	To include economic analysis and sector data.
National TEC data asset: initial specification	ITEC, March 2027	Define priority data, common measures and the requirements for a national TEC data resource.
State of the Sector report	ITEC, March 2027	Publish a national overview of the scale, reach and characteristics of TEC, identifying evidence gaps and opportunities for development.
Workforce adoption plan	April 2027*	Support wider adoption of TEC skills across assessment, care planning and service delivery.

Indicative dates, subject to programme planning and partner engagement.

The evidence supporting our recommendations.

1. Overview

The recommendations in Part 1 of this briefing draw on an independent evidence review by the Social Care Institute for Excellence (SCIE), a Theory of Change developed by economists Colligo Labs, TSA's Outcomes Framework and engagement with commissioners, providers and other sector stakeholders. This section examines the evidence in greater detail, setting out what can be said with confidence about the benefits of TEC in adult social care, where evidence gaps remain, the conditions needed to deliver value and the barriers preventing good practice from spreading.

2. The scale of TEC today

TEC is already a significant part of adult social care, supporting more than two million people to live safely and independently. TEC is the use of technology, together with the services and interventions around it, to support people's health, wellbeing, safety and independence. This distinction is central to the case for investment: the unit of investment is the care model, not the technology or devices on their own.

The evidence shows that TEC already creates value in defined contexts. That value can be understood across three connected forms of benefit: better outcomes and experiences for people and families, better use of scarce workforce and service capacity, and better use of financial resources. These benefits are related, but they are not interchangeable.

We also increasingly understand what conditions good TEC requires to deliver its benefits. Across the evidence and sector engagement, six conditions recur: person centred fit and trust, workforce capability and capacity, clear roles, workflows and response pathways, reliable infrastructure, usability, interoperability and data, leadership, commissioning and organisational readiness, and sustainability, adaptation and scale. Equity cuts across all six.

The challenge is that these conditions are not consistently present. Good local practice exists, but access and implementation vary, earlier identification does not create value unless services have the capacity to act, short term funding can trap services in repeated pilots, and the organisation investing in prevention may not be the organisation that receives the financial benefit.

The development of a National Care Service - alongside NHS reforms, such as neighbourhood health and the cornerstone shifts from hospital to community, analogue to digital and sickness to prevention - creates an opportunity to address those constraints. The task is not simply to deploy more technology but to make good TEC consistently available as part of mainstream care and support operating models.

Important evidence gaps for confirming TEC's benefits remain, particularly around long term outcomes, equity and wider economic impact and the attribution to TEC. Whilst these gaps should inform future evaluation, they should not delay action where the evidence is already sufficiently clear. There are opportunities to implement what we already know, strengthen the evidence through robust evaluation and reform the funding and incentive structures that impede TEC from scaling.

3. The opportunity for TEC within a National Care Service

Taken together, these findings give TEC a clear place within the development of a National Care Service. A future system organised around prevention, independence, joined-up neighbourhood health support and seamless movement between hospital, home care and community services should not treat TEC as a separate equipment offer. It should consider technology-enabled support as part of mainstream assessment, care planning, review and prevention.

In practical terms, TEC would make the early identification of changing care needs possible, connect information from people's homes to practitioners who have the role and capacity to act, support people to maintain independence before needs escalate, and use neighbourhood health services to provide a proportionate response. This is not a technology-first vision. Instead, TEC becomes integral to a wider care model in which assessment, professional judgement, workforce capability, response services, data, commissioning and funding arrangements determine whether earlier insight becomes earlier action.

This also creates a practical route for the Casey Commission to consider TEC within the architecture of reform. The central policy question is not whether a National Care Service should procure more technology. It is how national expectations, funding flows, workforce architecture, commissioning, data and neighbourhood health models can make effective TEC consistently available, while preserving local flexibility and individual choice.

A National Care Service also provides an opportunity to address inequalities in access to TEC. At present, whether someone benefits from technology enabled care can depend on where they live, how their local services are commissioned and the confidence of professionals in recommending it. Establishing consistent expectations for TEC within assessment, care planning and commissioned services would help ensure that access is determined by people's needs and preferences rather than local variation in provision.

This is also the point at which the distinction between TEC and technology matters most. Technology itself does not deliver prevention or better care. National policy can instead create the conditions in which technology-enabled support is considered routinely within assessment, care planning, review and prevention, with clear responsibility for response and with funding arrangements that recognise where value is realised.

4. What is TEC and why it matters now

There is no single, consistently applied definition of Technology Enabled Care (TEC) across policy and research. UK sector guidance describes TEC as a combination of technology and an organised care or response service that supports independence, prevention, safety and wellbeing. Academic literature often uses TEC more broadly, normally as an umbrella for telecare, telehealth, telemedicine, mobile health and other digital health services, while reviews of ageing-in-place technologies identify highly mixed terminology and many overlapping technology types.

As outlined in the Theory of Change framework developed for this work (Annex A), TEC is best understood not as a category of devices, but as a way of organising care and support around people. Therefore, TEC should be understood as the use of technology, together with the services and interventions around it, to support adults' health, wellbeing, safety and independence. The focus of this briefing therefore extends beyond the technology to the model of 'enabled care' it makes possible.

This definition is deliberately narrower than ‘digital social care’. It focuses on technology that is part of a care and support pathway and where there is a clear link between the technology, the response or intervention, outcomes for people, and potential system value. It therefore excludes general digital infrastructure where that link is absent, while recognising that infrastructure such as connectivity, interoperable records and data standards are essential enablers of TEC.

This framing also changes what it means to scale TEC. Scaling cannot simply mean purchasing or installing more technology. It means making good TEC more consistently available, reducing unwarranted variation in access and implementation, creating the conditions in which technology supports better care outcomes and ensuring the processes are in place to evaluate those outcomes.

This briefing considers both reactive TEC/ telecare, technology and associated activity used to detect, communicate or respond to an event once it has occurred, and proactive and preventative TEC, where technology, data and proactive intervention are used to identify emerging needs or risks and act earlier.

5. Scale and policy context

TEC already supports more than two million people, making it an established part of the care and support system.

At the same time, the policy landscape is moving rapidly. The NHS 10-Year Plan is organised around three connected shifts: hospital to community, analogue to digital and sickness to prevention (DHSC, 2025). Its neighbourhood model states that care should happen as locally as possible, digitally by default and in a person’s home where possible, with neighbourhood teams using data and predictive insight to support earlier intervention.

Neighbourhood health refers to creating healthier communities through improving services at a local level. This means transforming our health and social care system so that people can receive better care closer to or at home, and improving the integration of local services, especially across health and social care. The goal of neighbourhood health is to help people live healthy, active, and independent lives for as long as possible, whilst enabling people to better manage their own care.

For local areas, neighbourhood health should make care feel more accessible, community-driven, and more personal. People could benefit from developments like integrated care within joint spaces, extending opening hours, and personalised care plans.

These shifts sit within a wider programme of reform across health, social care and local government, and these changes create tangible opportunities for promoting an expanded role for TEC. The Casey Commission’s work is intended to inform the development of a National Care Service. The Prime Minister has announced his leadership of social care reforms and accelerated the Commission’s timetable. He set out principles for a future National Care Service, including seamless movement between hospital, home care and community services, prevention, independence and stronger alignment between local social, primary and community care (HM Government, 2026). The Health Bill is simultaneously reshaping NHS architecture, including the abolition of NHS England and provision for a Single Patient Record intended to enable more joined-up, proactive care (DHSC, 2026b). Local government reorganisation, devolution and finance reform add further change to the organisations responsible for commissioning and delivering adult social care.

TEC sits across these reforms. It can provide a route to support independence at home, detect changing needs earlier, connect information generated in people's homes to professional judgement, support reablement and falls prevention, and enable a more proactive relationship between neighbourhood health services and the people they support.

However, whilst TEC enables the models of care national policy is seeking to create, it cannot substitute for adequate workforce, proportionate regulations, sustainable local authority funding or the wider capacity of health and social care. TEC's strongest value proposition may be how it supports people's independence, enables earlier action and delivers better value from health and care resources, but these benefits need to be evidenced with greater precision rather than collapsed into a single claim of delivering 'savings' to the public purse.

6. What we know about the value of TEC

The evidence base is sufficiently developed to support action, but not to support undifferentiated claims about all forms of TEC. SCIE's review suggests that the evidence is strongest on implementation, acceptability, perceived benefits and the mechanisms by which TEC may improve care. It is less complete on whether TEC consistently produces measurable long term changes in health and social care service use or costs. The practical implication is to be clear about what is supported now, while building better evidence around the outcomes that remain uncertain.

A credible assessment of TEC's benefits should not be limited to financial savings. At least three connected forms of benefit should be considered: better outcomes and experiences for people who draw on care and support and their families, better use of scarce workforce and service capacity, and better use of financial resources. These benefits may reinforce one another, but they are not interchangeable. Improved reassurance or independence is valuable even where it does not immediately reduce expenditure, released staff time is not automatically a cashable saving, and a cost avoided by the NHS may require additional investment by a Local Authority, provider or family.

7. What can be said with confidence

SCIE's review of the available evidence, discussed in detail in Annexes A and B, allows the sector to be clear about the benefits that are supported now whilst identifying where further evidence is needed and how this additional evidence should be obtained and understood.

The evidence consistently identifies safety, reassurance and independence as important outcomes, particularly where TEC fits the person's needs, routines and preferences. Earlier identification of risk is also a credible mechanism: alerts, observations and sensor data can help practitioners understand changes in need and inform care planning. Yet the collation of data alone does not create value, value depends on whether the data are interpreted and acted upon.

Within existing evidence, there are stronger findings for particular applications and service models, including: evidence of reduced emergency attendance, admissions or length of stay in some digital care-home pathways and reductions in falls from particular local interventions. These examples show that specific TEC models can produce measurable effects. They cannot, however, be generalised into a claim that all TEC produces the same outcomes.

TEC can support social connection, reassurance and confidence as legitimate outcomes, not only risk management. The case for investment includes quality of life, independence, earlier intervention and system capacity, alongside costs. The economic case is most credible when it distinguishes cashable savings from avoided or deferred costs, released capacity, productivity gains and wider social value, and when the full cost of the service model is included (Gibson et al., 2025, LGA et al., 2024).

The current evidence of TEC's benefits and outcomes for people and care systems is therefore best described as uneven. The evidence becomes less conclusive as we assess longer term attribution, delayed escalation, residential care avoidance, net workforce release and financial savings.

8. Six conditions for good TEC

Across the evidence, the clearest finding is that successful TEC adoption and implementation depends not on the technology alone but on the technology combined with the system of people, skills, infrastructure, workflows and responses around it. Across the studies reviewed, six recurring enabling conditions emerge.

Equity cuts across all six conditions. Access to TEC depends on affordability, trust, digital confidence, connectivity, accessible design, information and local service availability. TEC could narrow inequalities if it expands access to earlier, personalised support, it could also widen them if services are designed around people who already have digital skills, reliable connectivity, family support or the ability to self-fund. As a future care and support system develops, equity therefore needs to be designed and measured as a core outcome of TEC deployment, not treated as an afterthought.

The six enabling conditions include:

Person centred fit, trust and participation	TEC is more likely to be adopted and sustained when it is matched to the person's life, preferences, abilities and support network. Acceptability depends not only on whether a device functions technically, but on whether people understand its purpose, trust how it will be used, can afford and access it, and feel that it complements rather than replaces valued human care. Co-production, when people come together as equals to make decisions or create services that work for them all, should extend beyond product design into assessment, commissioning and delivery. People who draw on care and support, unpaid carers and frontline staff need to shape the offer, with ongoing human support available as needs and routines change (Gibson et al., 2025, Doyle et al., 2024).
Workforce capability, capacity and the hidden work of TEC	TEC changes the nature of work rather than eliminating or replacing it. Assessment, installation, training, monitoring, interpretation, troubleshooting, response and care-plan review all require time and capability. That work may sit with care staff, clinicians, TEC providers, suppliers or unpaid carers. Where this is not recognised, technology can increase workload or transfer responsibility when not properly resourced, rather than release capacity. Practical training, protected time, local support and clear responsibilities are therefore core components of the intervention, not optional implementation extras (Hamblin, 2022, Glasby et al., 2023).
Clear roles, workflows and response pathways	TEC only becomes a beneficial intervention when information leads to action. This is particularly important for proactive TEC: the value proposition depends on moving from data capture to insight, review, action and earlier intervention. Effective TEC models specify who receives information, who interprets it, what response is available, when issues are escalated and how learning feeds into assessment and care planning. Where responsibilities are unclear across health, social care, TEC providers and families, information can become disconnected from practice.
Infrastructure, usability, interoperability and data	Technical reliability is necessary but not sufficient for the adoption and spread of TEC. Connectivity, accessible design, supplier responsiveness, data quality, information governance and interoperability all affect whether TEC can be deployed meaningfully. The deeper question is whether the information generated is timely, trusted and usable by the people expected to act on it. The direction of national policy, from 'Care Data Matters' to the Health Bill's Single Patient Record, creates a more favourable environment for joined-up information, but data generated from TEC deployment still needs clear standards, governance and routes into local workflows if it is to contribute to coordinated care (DHSC, 2023, DHSC, 2026b).

Leadership, commissioning and organisational readiness	TEC is more likely to succeed when it is treated as service transformation rather than technology procurement. Strategic leadership, shared objectives, realistic funding, cross-system collaboration, staff engagement and an agreed evaluation approach need to be in place before a product is rolled out. Commissioning should be grounded in a clear Theory of Change which covers the whole pathway - assessment, installation, monitoring, response, review and evaluation - and recognise that costs and benefits may fall across different organisations. This matters in a system where immediate operational pressures can crowd out investment in prevention and longer term change.
Sustainability, adaptation and scale	Initial adoption of TEC is not the same as sustained implementation. TEC can be installed and initially welcomed, but fail to become embedded if support falls away, staff change, the technology no longer fits the person, data findings are not acted on, or ownership becomes unclear. Services need long term ownership, ongoing review, technical and practical support, learning across sites and integration into routine commissioning and evaluation. Evidence on these conditions is relatively strong, evidence on sustained scale, especially for proactive and preventative models, is much weaker (Gibson et al., 2025, Potter et al., 2025).

Why these conditions are not consistently present

The sector engagement undertaken suggests that the next challenge is less about proving that individual technologies can work and more about creating the operating, funding and accountability conditions in which good TEC can become routinely available. The problem is not an absence of mature local practice, it is that this practice is not yet the norm.

Variation in access and practice

This points to an important distinction between the maturity of TEC practice and the consistency of that practice across the country. People with lived experience and other sector representatives continued to describe variation in what is available, what practitioners know about, and when technology is discussed. Earlier access was also seen as important: if TEC is introduced only once someone reaches formal social care or a point of crisis, much of its potential contribution to prevention has already been lost.

The policy implication is therefore more nuanced than a generic call for greater awareness or more person centred commissioning. There is an emerging body of local practice from which to learn. The more useful question is what distinguishes places where TEC has become part of routine, needs led care from those where it remains peripheral, and which elements of those models can be transferred without creating a standardised technology offer. This also suggests that future investment should be concerned with reducing unwarranted variation in access to good TEC, rather than simply increasing the number of technologies deployed.

The critical gap between information and prevention is the capacity to act

Easily overlooked is a significant constraint on the preventative case for TEC. Earlier identification only has value if earlier action is possible. Where local services are already operating under significant pressure, additional information can identify unmet need without creating the capacity to respond to it. Uncertainty about the responsibility for effective and timely responses to information arising from TEC can lead to a conventional response, such as increasing care hours, rather than consideration of a different technology-enabled or preventative intervention.

The issue is therefore as much about operating models as it is actionable data. Some local authorities described deliberate attempts to close this gap by bringing occupational therapy or social care expertise into proactive monitoring teams, recording TEC within shared health and care records, and making ownership of risk and response more explicit. These examples begin to show what a functioning proactive pathway looks like in practice: technology generates information, but professional judgement, service capacity and clear accountability determine whether that information changes care.

For policymakers, this places an important boundary around claims that better data or more sophisticated monitoring will, by themselves, shift care towards prevention. Investment in proactive TEC needs to consider the response capacity alongside the technology. It also identifies a useful focus for further evidence: not simply whether monitoring detects risk, but which response models can convert earlier insight into better outcomes and reduced or delayed escalation.

Fragmented and perverse incentives

The review found that the economic evidence for TEC is less developed than the evidence on implementation. Sector engagement reinforced the need for stronger evidence but also exposed a separate problem: even a credible economic case may not lead to investment where costs and benefits fall in distinct parts of the system.

During the sector engagement, this was particularly clear from local authority and commissioner perspectives. A social care-funded responder service may avoid an ambulance call-out or hospital attendance, investment by a provider may create benefits for a commissioner, and technology that supports someone to remain independent may defer future expenditure without producing an immediate saving in the budget that paid for it. The organisation carrying the upfront cost and implementation risk may therefore capture only part of the value created.

This helps explain why return on investment can be simultaneously persuasive at system level and difficult to act on locally. It also reinforces the distinction made earlier in the briefing between cashable savings, avoided or deferred costs, released capacity and wider social value. These are not only different forms of benefit, they may accrue to different organisations over different time horizons.

The sector discussions pointed towards pooled and joint funding as part of the answer, including the potential use of the Better Care Fund, but local experience was mixed. The more fundamental issue is whether current commissioning arrangements can invest across organisational boundaries when the return is distributed across health and social care. This is an area where further work could materially strengthen the economic case: mapping the flow of costs and benefits through representative TEC pathways, identifying where existing funding arrangements inhibit investment, and testing how financial risk and return could be shared more effectively.

Short term funding cycles

The evidence review identified a recurring reliance on pilots and limited evidence of sustained implementation at scale. The sector engagement suggests that this is not simply a research weakness, it reflects the way innovation is often funded and commissioned. Short term funding can make it possible to test a technology, but not necessarily to redesign the service around it or to meet the recurrent costs once the pilot ends. Organisations can also find themselves running an existing service and a new model in parallel while trying to demonstrate the evidence required to justify change.

This creates a circular problem. Commissioners seek stronger evidence before committing recurrent funding, but the conditions needed to generate that evidence - sufficient scale, duration and service redesign - may themselves depend on longer term investment. The result can be repeated proof-of-concept activity that demonstrates that a technology is feasible without establishing whether the model can become routine care.

For national policy, the implication is not that local innovation should be curtailed. It is that more value could be extracted from it. A clear Theory of Change incorporating common outcomes and evidence expectations, stronger sharing of implementation learning and more deliberate support for promising models to move beyond the pilot stage would reduce the need for every area to prove the same propositions independently. This would also help redirect evaluation towards the questions that remain genuinely unresolved, for example long term prevention, workforce impact, equity, economic value and sustained scale, rather than repeatedly testing whether individual technologies can work.

Annex A - Approach and analytical framework

The evidence findings used throughout the briefing to assess the value case for TEC, particularly in TSA's position and the evidence section were drawn from a set of activities grounded in an analytic framework.

Describing the benefits of TEC: Using the TSA's Outcomes Framework and Colligo Labs' Theory of Change

The evaluation framework used in this briefing brings together the Outcomes Framework developed by TSA and Alice Ainsworth, which sets out what TEC should ultimately achieve, and a Theory of Change, developed by Colligo Labs which sets out how TEC, the technology and the care wrapped around it, is expected to produce those outcomes for all the stakeholders. The framework was tested and refined through the roundtables and sector engagement described in Annex B.

The TSA's Outcomes Framework: what success looks like

The Outcomes Framework is organised around a Quintuple Aim and drawing on the Adult Social Care Outcomes Framework (ASCOF) and the Making It Real statements. It describes success at two levels.

Long term outcomes (5 years+) describe what is different for people, carers, the workforce and the system once TEC is embedded well. These are the five aims used to organise the outcomes referred to throughout this briefing (Table 1):

Table 1: The Quintuple Aim outcomes

Outcome	What success looks like	Illustrative indicator
Equity of access	People who could benefit from TEC can access appropriate support regardless of where they live or whether they meet a formal eligibility threshold. The postcode lottery is substantially reduced.	Variation in TEC access across local authority areas is tracked and narrowing.
Quality of life and health outcomes	People stay safe, live with dignity, remain connected and independent. TEC supports prevention and early intervention, not only crisis response.	People using TEC report improved quality of life, safety and wellbeing.

People's experiences of care	Care is personalised and joined up. Information flows with the person. Self-funders have access to the same quality of information as those in funded care.	People report informed choice, continuity and not having to repeat their story.
Workforce experience	The care workforce is confident and skilled in TEC. Staff spend more time with people than on avoidable reactive or task-driven work.	Staff report confidence in using TEC and reduced reactive burden.
Productivity, efficiency and sustainability	The system makes better use of scarce resources. Avoidable escalation is prevented or delayed where TEC contributes to this, and the economic case is independently evidenced.	Transparent, independently validated benefit-cost evidence is available and used in commissioning.

Medium-term outcomes (12–36 months) describe the conditions that need to be in place for the long term aims to be reachable, organised across four change domains: policy and evidence, building demand, ensuring supply, and the care workforce. These are the levers through which the Quintuple Aim is expected to be achieved, and they inform the recommendations set out in this briefing and the discussion in Annex C.

A deliberate feature of the framework is that financial return is one dimension of success among five, not the overall test TEC must pass. Cashable savings sit within productivity and sustainability alongside better use of scarce workforce capacity and better outcomes and experience for people and families. They are three related but distinct forms of value that this briefing identifies, which can ultimately be pulled together to develop an overall Social Return on Investment (SROI) to support investment decisions.

The Theory of Change: how TEC is expected to work

The Theory of Change sets out the mechanism which connects TEC to those outcomes. As per HM Treasury recommendations it should be the first step in any evaluation.

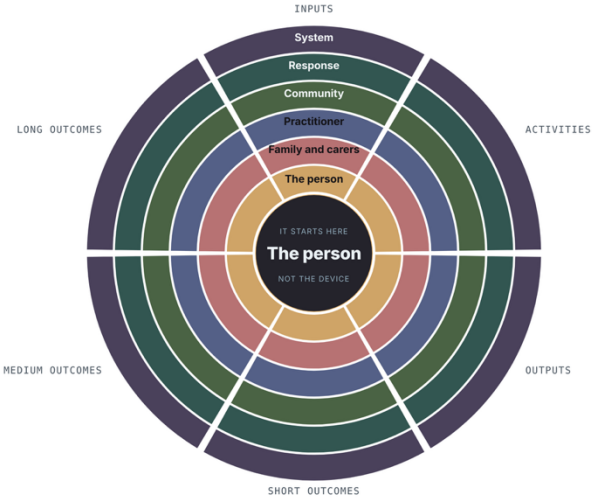
The Theory of Change for TEC development can be visualised as six concentric rings, centred on the person in receipt of the TEC services: the person, family and carers, the practitioner, the community, the response, and the system. The experience of each ring can be tracked through the same six stages of classic Theory of Change, inputs, activities, outputs, and short, medium and long term outcomes.

START HERE

The device is not the intervention

A sensor without triage, response, review and a care plan that carries it produces detection and nothing else. What is being evaluated is the technology together with the care wrapped around it.

The person is at the centre. Everything else is arranged by how close it sits to them and the chain runs clockwise through time.



WHO SETS THE CONDITIONS

System, inputs through to long outcomes

INPUTS
A neighbourhood health plan, pooled funding and a baseline to measure against

ACTIVITIES
Technology, response and the community commissioned together

OUTPUTS
A service running with spend and reach visible

SHORT OUTCOMES
Workforce time released and the providers still viable

MEDIUM OUTCOMES
Packages held rather than escalated, conveyance and admission reduced

LONG OUTCOMES
The same outcome wherever they live, cost attributed and the service turns proactive

Theory of Change Wheel © Colligo Labs 2026

As outlined in the briefing's definition of TEC: the technology is not the intervention. An outcome depends on a chain holding together: detection, triage, an available response, and review. If any link in that chain is missing or weak, the outcome may not follow. Earlier identification of a change in need, for example, only becomes prevention when it results in an effective response, detection without a commissioned response behind it produces no benefit at all.

Because no single link in that chain can be isolated as "the cause," the Theory of Change sets a deliberately disciplined ladder for the claims this review makes about evidence:

Describe - what was delivered, to whom, and at what cost, with outcomes reported as observed among those who received it.

Compare - a stated difference against a comparator or baseline, together with what else could plausibly explain it.

Contribute - the share of the change plausibly produced by the bundle of technology and care, alongside other things that were happening, with that share and its uncertainty stated.

Because it names what each ring depends on, the Theory of Change also anticipates where value can be lost even when implementation looks successful on the surface. For example, response load shifting silently onto unpaid carers rather than being relieved, technology substituting for human contact rather than adding to it, equal access producing unequal outcomes across areas, or installation and activation being counted as outcomes. These are not hypothetical risks: several are independently confirmed by the evidence gaps identified through the literature review, which gives the review a degree of confidence that it is asking the right questions of the evidence base.

The model is built to align with HM Treasury appraisal practice, so that the review's economic and wellbeing claims can be tested against the same standards used elsewhere in government: the Green Book for valuing forward investment, the Magenta Book for evaluating what has happened. In both cases incorporating the Wellbeing Supplementary Guidance for valuing outcomes that are not readily monetised.

A structured review of existing literature

Using this evaluation framework, SCIE undertook a structured evidence review to assess what can currently be said about the value of TEC, where the evidence is strongest, and where further evidence is needed. It was not a full systematic review. Its purpose was to independently assess what each source showed, whether findings were positive, mixed, negative or inconclusive, and how confidently they could be used.

Sources were screened against the project definition of TEC and included where they related to technology used as part of a care and support pathway, with a plausible link to outcomes for people, services or the wider system. Sources outside this scope, such as general digital infrastructure or technology with no clear care and support pathway, were excluded or treated as out of scope.

For each included source, SCIE extracted key information on the TEC model, population, setting, methods, outcomes, findings, quantitative results, limitations, UK relevance and transferability.

SCIE appraised academic and grey literature using criteria appropriate to the source type, including methodological quality, transparency, credibility, use of data, limitations and risk of overclaiming. Evidence strength was judged by how much weight could safely be placed on each source, not by whether it was favourable to TEC.

Overall, the review found that the evidence is strongest on implementation, acceptability, perceived benefits and mechanisms of change. It is less complete on long term attribution, delayed escalation, sustained service-use change, workforce impact and economic value. This means claims need to be made at the right level of specificity, with person centred outcomes, pathway conditions and system impacts considered together.

The challenges of evaluating the benefits of TEC in social care

As outlined in the Theory of Change, TEC is not a single, standardised intervention, the same device can produce very different outcomes depending on who uses it, the purpose for which it is introduced, the quality of assessment, the response pathway, the workforce and family support around the person, and the local services available when information or an alert indicates a need for action. As such, evaluating its impact is challenging.

Outcomes are produced by the wider pathway around it: assessment, monitoring, triage, response and follow up. For example, if a fall does not lead to an ambulance attendance, the relevant mechanism may include the sensor, the speed of triage, a responder service, lifting equipment, a family member or access to an alternative clinical pathway (Glasby et al., 2023, Health Innovation Network, 2023). This means evaluations need to look at the whole pathway, not just the device.

This complexity is compounded by inconsistent terminology and outcome measures. Studies use telecare, TEC, connected care, remote monitoring and digital care in overlapping ways, while interventions range from pendant alarms to GPS devices, digital falls tools and sensor-based monitoring. Populations, settings, comparators and follow up periods also vary. Much of the evidence concerns pilots, early implementation or local case studies. This makes aggregation difficult and means that a positive finding for one model should not automatically be generalised to a different technology, cohort or response arrangement.

There is also a practical challenge in evaluating innovation while services are changing. The Health Foundation's work on testing innovation emphasises the need for approaches that can evaluate complex initiatives while supporting learning and improvement, rather than assuming that conventional evaluation designs will always fit rapidly evolving services (Health Foundation, 2026).

Adult social care faces a further capacity constraint: The King's Fund found that local authorities often struggle to define shared approaches to improvement, articulate a clear theory of change and measure impact, in part because of pressure on resources and the quality and availability of data (Cream et al., 2022). TEC evaluation therefore needs to be focused and proportionate enough to be feasible locally, and consistent enough to build a cumulative national evidence base.

Annex B Evidence review and sector findings

The evidence assessment undertaken by SCIE drew on a wider body of research and published material than is reproduced in the references to this briefing. A full list of sources considered during the assessment is available on request.

What can be said with confidence now

SCIE's review of the available evidence suggests it is strongest on implementation, acceptability, perceived benefits and the mechanisms by which TEC may improve care. It is less complete on whether TEC consistently produces measurable long term changes in service use or costs. In other words, the evidence allows the sector to be clear about the benefits that are supported now while identifying where further evidence is needed and how this additional evidence should be obtained and understood.

Feeling safer and more reassured at home

This is a recurring finding in qualitative evidence, particularly in relation to established telecare. TEC can also support independence where it fits the person's needs, routines and preferences, rather than being introduced as a standardised product. For unpaid carers, technology can provide reassurance and a clearer route to support when risk or deterioration arises, although evidence is less certain on whether this translates into a sustained reduction in overall carer burden (Gibson et al., 2025, Doyle et al., 2024).

Earlier identification of risk

The evidence supports this more strongly as a mechanism than a universal downstream outcome. Alerts, observations and sensor data can help practitioners understand changes in need and inform care planning, but data alone do not create value. The intervention occurs when information is interpreted and acted upon. This is consistent with the NHS 10 Year Plan's wider emphasis on making predictive information meaningful through changed care and response, rather than treating insight as the end point (DHSC, 2025a).

Better outcomes for people

There is credible evidence on needs, acceptability, user priorities, implementation conditions and the mechanisms through which TEC can contribute to better care. There are also stronger findings for particular applications: for example, a retrospective study of the Health Call digital care-home pathway reported reductions in emergency attendances, emergency admissions and length of stay, while a real-world evaluation of the Safe Steps digital falls intervention found reductions in falls in one of two boroughs and fewer low-harm injurious falls in the setting where outcome data were available (Hodgson et al., 2024, Vaportzis et al., 2023). These studies are important because they show that specific models can produce measurable effects. They do not, however, justify assuming that all TEC will generate the same outcomes.

The conception of value

The upshot is that a stronger evidence base will require measurement to follow the logic of person centred care within a clear Theory of Change for the development of TEC rather than defaulting to what is easiest to count. Hospital admissions, ambulance callouts, care hours and costs are important measures, but they do not by themselves show whether someone feels safer, has more control, remains connected, can continue meaningful activities or experiences care as less intrusive. Nor does installation or activation show that TEC is being used, acted on or delivering value.

What's missing from the evidence?

The main evidence gap is not the absence of positive examples. It is the level of confidence with which those examples can be attributed to TEC, generalised across settings and sustained over time.

SCIE's review found that the 'front end' of the causal pathway is comparatively well supported: there is credible evidence on user priorities, acceptability, implementation conditions and adoption. Across the underlying studies, the evidence becomes less complete as the pathway moves towards long term outcomes, service utilisation, delayed escalation and economic impact (Gibson et al., 2025, Glasby et al., 2023, Health Innovation Network, 2023, Potter et al., 2025). Five gaps are particularly important for the next phase of evidence development.

Robust outcome evidence, attribution and long term scale

Robust comparative evidence showing that TEC itself causes reductions in hospital admissions, ambulance use, falls, escalation of care, residential care admission or social care utilisation remains limited. This does not mean those outcomes do not occur. Specific studies demonstrate measurable effects, and many evaluations report promising or perceived benefits. The problem is attribution and transferability. The London remote-monitoring evaluation, for example, found widespread implementation but no clear observable pattern in healthcare utilisation data, while the NIHR home-sensors study could not demonstrate anticipated outcomes because the technology did not generate the data required to support them (Health Innovation Network, 2023, Glasby et al., 2023).

Implementation evidence is stronger than outcome evidence. We know much more about the conditions associated with successful adoption - person centred assessment, training, infrastructure, leadership, clear response pathways and ongoing support - than about which component of the pathway produces a downstream effect. Long term evidence is also thin. Much of the literature concerns pilots, early implementation or short follow up, leaving questions about technology replacement, staff turnover, changing user needs, subscription and connectivity costs, alert volumes and organisational adaptation under developed. The DECIDE review similarly found strong interest in proactive connected care but limited evidence of real world impact and scaled routine implementation (Potter et al., 2025). Future studies need explicit theories of change, clearer comparators, longer follow up, in order to make the contribution of different pathway components testable.

Economic evidence and the reality of 'savings'

Economic evidence is currently lacking in the TEC business case. There are substantial claims about avoided costs and savings, but relatively few studies provide transparent methods, full cost data and robust counterfactuals. A central problem is conceptual as well as methodological: cashable savings, avoided costs, deferred costs, released capacity, productivity gains and wider social value are often treated as though they are the same. They are not. A reduction in avoidable ambulance use may release capacity without reducing a budget, delaying residential care may defer expenditure rather than eliminate it, and better quality of life may create substantial social value without appearing as a saving to a commissioner.

Going forward, we need to consider the total costs of adoption and deployment, and which organisations bear these costs and where do the benefits occur. TEC costs extend beyond equipment and licences to assessment, installation, training, connectivity, maintenance, monitoring, interpretation, response, management, information governance, decommissioning and replacement. The wider prevention literature offers a useful discipline here: the LGA-led prevention model explicitly distinguishes direct costs averted from wider societal value and cautions that value realised across organisations and over time will not necessarily create immediate cash flow reductions (LGA et al., 2024). TEC evaluation should apply the same precision, including transparent assumptions about which organisation bears costs, which receives benefits and over what period.

Person centred outcomes are valued, but not measured consistently

The literature is clear about many of the outcomes people value from TEC: independence, control, safety, reassurance, connection, confidence and trust. It is much less consistent in measuring whether those outcomes change over time using validated or comparable tools. This creates a risk that evaluation becomes system-centred precisely where TEC should be person centred. Hospital admissions and care hours are easier to count than whether someone has greater choice, can continue meaningful activities, remains connected to others or feels more in control of their support (Gibson et al., 2025).

This gap matters for both policy and commissioning. If the identified outcomes focus on service utilisation, TEC models that improve people's lives without generating immediate system reductions may be undervalued, conversely, a service that reduces activity but diminishes choice or replaces valued human contact could appear successful. Future evaluation should therefore combine common quantitative measures with person reported outcomes and qualitative evidence about what matters to individuals. As the Health Foundation argues, person centred measurement requires a logic that connects processes and outcomes and is co-designed around the person rather than the organisation (Collins, 2014).

We do not yet know enough about what works for whom

The evidence does not suggest treating TEC as a single intervention. Different technologies, functions, populations, settings and response pathways are likely to produce different outcomes. Success depends on the interaction between the person, the technology, the care pathway, workforce and local context. A model that is effective for one person may be intrusive, inaccessible or burdensome for another. The central unanswered question is therefore: which TEC function, with which service response, works best for which person, at which point in their care journey, and under what circumstances? (Glasby et al., 2023, Gibson et al., 2025, Doyle et al., 2024).

The evidence base is also concentrated in particular populations and settings, especially older people, dementia, care homes, hospital discharge, reablement, remote monitoring and reactive telecare. There is less robust evidence for working age adults, people with learning disabilities, autistic people, people with mental health needs or sensory impairments, self-funders and people earlier in the care journey. This is also an equity issue as it means we do not know what works well or best for everyone. SCIE's wider care equity research shows that geography, resources, disability and digital confidence can shape people's ability to navigate and benefit from care. Future TEC research needs more representative samples and routine analysis of differential offer, uptake, non-use, abandonment and outcomes by relevant characteristics and local context (SCIE, 2026).

Prevention: ambition is ahead of the evidence

The shift from reactive telecare towards proactive, preventative and predictive TEC is central to the sector's future ambition, and it aligns closely with national policy. The causal logic is persuasive: collect relevant information, identify a change in need or risk, review it, act earlier and prevent or delay an adverse outcome. But we need the evidence to catch up with that ambition. Proactive models are still more commonly represented by pilots, early implementation and promising case examples, and we need robust comparative, longitudinal evidence at scale (Potter et al., 2025, Glasby et al., 2023).

Delayed escalation and residential care avoidance are therefore particularly important but under evidenced outcomes. A GPS dementia study suggests the possibility of delaying 24-hour care, but stronger longitudinal and comparative evidence is needed before this type of finding can be generalised (Doyle et al., 2024). Prevention is also inherently difficult to demonstrate because the outcome is often something that did not happen, may occur months or years later, and may depend on several services acting together. Future evaluation needs to follow the whole pathway from signal to response to outcome, with linked longitudinal data where possible, rather than infer prevention from activity alone.

Taken together, these gaps point to the next task for the TEC evidence base. The sector does not need to wait for perfect evidence before acting, but it does need greater consistency in definitions, outcome measures, theories of change and data collection, stronger independent evaluation, and a clearer distinction between what is established, what is promising and what remains a hypothesis. That is the foundation for the more robust framework and evidence programme set out in Annexes C and F of this briefing.

Insights from the sector: Sense checking the evidence review's findings

To sense-check the evidence identified through the review, three sector roundtables were convened with different parts of the social care sector, including people with lived experience, care providers, workforce representatives, local authorities and local decisionmakers.

The discussions broadly supported the central findings of the review, but they also qualified them in important ways. In particular, they suggested that some of the barriers described in the literature are changing as local practice matures, that the gap between evidence and adoption is partly explained by the way funding and accountability are organised, and that the practical implication is increasingly one of moving from isolated examples of TEC to sustainable service models. This shift challenges usual practices for commissioning TEC and public service funding models.

This sense-checking also draws on a separate engagement by the TSA with local authority finance leaders to explore their concerns regarding investment in TEC. This engagement was conducted ahead of the roundtable series and finance leaders were not separately represented across all three roundtables, so their perspective is reported here as a distinct strand of sector testing, alongside the roundtable findings that follow.

Local practice is more mature than a simple 'barriers to adoption' narrative suggests

The literature identifies person centred fit, trust and participation as important conditions for TEC adoption. Sector engagement did not challenge that principle, but it did challenge the implication that social care practice remains uniformly product led or that personalisation is still a major barrier in the same form as it may have been several years ago. Local authority representatives described services that are already needs led and supplier agnostic, with technology selected around the person, their home, existing support and the outcome being sought. In some areas, new technologies are also being considered through more formal pipelines that test safety, practical fit and return on investment before they enter routine use.

The critical gap between information and prevention is the capacity to act

The evidence review identifies clear response pathways as a necessary condition for TEC to create value. The sector engagement sharpened this point. For local decisionmakers, the practical issue is not simply whether technology can identify a change in behaviour, need or risk, but whether the care system has somewhere useful for that information to go. Representatives described situations in which proactive monitoring generated potentially valuable insight, but the receiving practitioner did not necessarily have the time, role or service options required to translate it into a different response.

Fragmented and perverse incentives

Provider incentives also matter. For organisations operating with limited financial headroom, TEC can introduce training costs, implementation risk and new responsibilities before any benefit is realised. Expecting providers to adopt and sustain new models without recognising those costs in commissioning arrangements is unlikely to produce consistent change. The investment question therefore extends beyond the public sector purchase of technology to the incentives facing the organisations expected to use it.

Short term funding cycles

There are signs that local practice is beginning to respond. Some authorities described becoming more selective about pilots, requiring a clearer strategic fit, an identified service model and a credible route to ongoing funding before testing begins. This is a significant shift: sustainability becomes part of the decision to invest, rather than a question left until temporary funding is exhausted.

For national policy, the implication is not that local innovation should be curtailed. It is that more value could be extracted from it. Common outcomes and evidence expectations, stronger sharing of implementation learning and more deliberate support for promising models to move beyond the pilot stage would reduce the need for every area to prove the same propositions independently. This would also help redirect evaluation towards the questions that remain genuinely unresolved, for example long term prevention, workforce impact, equity, economic value and sustained scale, rather than repeatedly testing whether individual technologies can work.

The finance leadership perspective: proof, risk and who goes first

The roundtables tested whether the evidence review's findings held up against operational experience. The engagement with local authority finance teams explored concerns regarding how TEC investment could clear their investment sign-off process. Local authority finance leaders were broadly supportive of TEC with several describing services that intuitively 'felt right'. Their concerns were concentrated in how investment risk is owned, how savings claims are treated once made, and whether the evidence put in front of them could be trusted. This points to additional challenges distinct from the evidence gaps described above.

Finance leaders were explicit that much of the evidence available to them originates from suppliers with a commercial interest in the outcome, which materially reduces its weight in an internal business case. This reinforces the message from this briefing that independently validated evidence, not reliant on vendor sourced or self reported data, is a requirement for TEC related investment decisions.

A second, distinct barrier was cultural. Participants described a persistent fear of being associated with a potentially wasteful project, and a reluctance to be the first authority to commit, even where TEC felt intuitively right. This scepticism was described as widely shared: authorities are broadly agreed that they will invest once a case has been clearly demonstrated elsewhere. The effect is a form of collective hesitation in which the evidence needed to build sector wide confidence can only be generated by authorities willing to act without it.

This hesitation was reinforced by direct experience of market instability, including authorities that had seen supplier failures. The resulting concern was less about any single technology and more about the sustainability of the market behind it. Finance leaders wanted assurance of supplier viability, interoperability and exit options before committing to longer term investment.

A further, more specific dynamic emerged around savings claims themselves. Several finance leaders described an internal tendency, once a service commits to a projected saving, for that saving to be treated as a target for budget reduction rather than as a benefit to be realised and reinvested. This creates a disincentive to state savings figures at all, independent of whether the underlying evidence supports them. More broadly, finance leaders were clear that cost avoidance, efficiency and improved outcomes are valued, but are not, on their own, sufficient without demonstrable and credible financial savings. This inevitably highlights the tension between the reality of decision making within local authorities which is often cash based and the recommended use of a rigorous, comprehensive and HM Treasury compliant SROI approach.

The finance leadership perspective reinforces the message that closing the evidence gaps is only part of the solution. Successful and sustained TEC deployment also needs to address the ownership of risks, savings and benefits.

Annex C Implementation and learning

What needs to happen to ensure TEC has a clearer role in the future of social care

Taken together, the evidence review and sector engagement point to a shift in the challenges facing TEC adoption and spread. The evidence base is increasingly clear about the conditions associated with effective implementation, while experience from parts of the sector shows that more mature, needs led models are already possible. The more difficult constraints increasingly sit between organisations and over time: who is able to act on the information TEC generates, who invests in preventative support and who captures the benefit, how workforce and service capacity adapt around new models of care, and how promising approaches move from temporary funding into routine provision.

This changes the nature of the opportunity. The next phase of TEC cannot be principally about increasing the volume of technology in social care, nor about continuing to demonstrate through isolated pilots that individual technologies can work. Earlier sections have shown why TEC needs to be understood as part of the care and support model itself: technology combined with the assessment, workforce, response and services required to translate it into outcomes. The question for the next phase is how to make those models sufficiently investable, sustainable and consistently available that TEC can contribute at scale to a more preventative model of social care.

Infrastructure for prevention and the role of TEC

Much of established telecare has been organised around responding when something has already happened. The larger opportunity is to extend TEC further upstream: supporting independence before formal care needs escalate, identifying changes earlier, and enabling timely review or intervention. This is consistent with what people in the roundtables described as valuable, maintaining privacy, choice, connection and ordinary life, and with local authority interest in routes to technology before people reach a statutory service response.

That shift has implications for access. If TEC is principally encountered through eligibility for formal social care, its preventative potential is necessarily constrained. Earlier access will require clearer routes through community services, housing, primary care, voluntary organisations and self-directed support, alongside better information for people who may purchase technology themselves. It also requires care not to create a two-tier model in which earlier access depends on personal income, digital confidence or geography.

Prevention should nevertheless be treated as an investable proposition that still requires evidence development, not as a benefit that can simply be assumed. The causal pathway is plausible and increasingly practicable, but the review found limited longitudinal evidence showing that proactive TEC consistently delays escalation or reduces subsequent service use at scale. Future investment should therefore build delivery and evaluation together, following the pathway from signal, to interpretation, to response, to outcome over a sufficiently lengthy period. Effectively, the investment should be built on a clear evaluation framework: a documented Theory of Change which feeds through to an Outcomes Framework.

The unit of investment is the care model, not the technology

Technology on its own is rarely the intervention. Value is created through the combination of technology, assessment, workforce practice, information, response and review. This distinction matters because capital or procurement led approaches can make deployment appear easier than transformation. A device can be installed while the surrounding service continues to operate in exactly the same way.

Investment decisions should consequently account for the whole operating model. Assessment and personalisation, staff capability, monitoring, interpretation, response, technical support, connectivity, data governance, maintenance and review are not ancillary costs, they are part of what makes the technology effective. This also changes how productivity should be understood. TEC may remove or reduce some activity, but it can create new work elsewhere. The relevant question is whether the redesigned pathway makes better use of total capacity while improving outcomes, rather than whether a device removes a particular task.

There is already useful practice to build from. Local authorities in the roundtables described needs led and supplier agnostic approaches, dedicated TEC expertise embedded alongside frontline teams, explicit pipelines for assessing innovative technology, and clearer arrangements for risk and response. These examples suggest that the next stage of development is less about finding more products and more about codifying, testing and spreading the service models that allow technology to become part of ordinary care practice.

The economics of TEC need to reflect where value is realised

One of the clearest barriers exposed by the roundtables and feedback from the local authority finance community is the mismatch between investment and return. TEC funded through social care can reduce demand or release capacity elsewhere, a responder service may prevent an ambulance journey or hospital attendance, a provider may incur the cost of training and changing practice while another organisation benefits, and families may gain reassurance while also assuming new responsibilities. Value is distributed across the system, but budgets and accountability remain substantially organisational.

As such, a positive whole system return does not automatically translate into a viable local investment decision. The case for TEC will remain constrained while the organisation expected to fund a service cannot recognise enough of the resulting benefit within its own budget or planning horizon. Even where a credible saving can be shown, services may be reluctant to state it if doing so triggers an expectation that the equivalent budget will be removed rather than reinvested. More money alone does not resolve this problem if the underlying incentives remain fragmented.

There is therefore a practical policy question about how preventative investment is shared. Existing pooled and joint funding arrangements, including the Better Care Fund, provide a starting point, but the roundtables suggest that access to these mechanisms for TEC is inconsistent and can remain shaped by organisational priorities. Further work should map costs, avoided and deferred expenditure, released capacity and cashable benefits across representative TEC pathways, then test which commissioning and funding arrangements can share investment and return. This would move the debate beyond generic claims of return on investment towards the financial architecture needed to act on it.

Workforce capability

The workforce emerges from this work not simply as an implementation barrier but as one of the principal mechanisms through which TEC creates, or fails to create, value. Practitioners determine whether technology is considered in the first place, whether it is matched well to the person, whether information changes a care plan and whether a service continues to adapt as needs change. Roundtable participants also highlighted a behavioural dimension: adoption is easier when staff can see how technology improves their own ability to do the job, rather than experiencing it as an additional initiative or training requirement.

This points beyond one-off TEC training. To develop capability, there needs to be professional education, continuous learning, specialist roles and embedded expertise that can support assessment and review. Local examples of TEC specialists working alongside social care teams suggest a potentially important model. What remains less clear is which workforce models produce the greatest improvement in appropriate adoption, sustained use and staff capacity. That is a tractable evidence question and one with direct relevance to investment decisions.

Digital resilience is becoming a condition of safe social care

The transition from analogue telecare changes the significance of connectivity. The sector engaged as part of this briefing described mobile outages, areas without viable broadband or mobile coverage and situations in which services had limited fallback when networks failed. For people whose safety depends on a connected service, this is not simply a digital inclusion issue. It is a question of care continuity and system resilience.

As TEC becomes more proactive and connected, the dependency grows. National ambitions for TEC will therefore need to be matched by clearer expectations for resilience, fallback, interoperability and the treatment of critical telecare during network disruption. There is also an equity consequence: a person should not be excluded from an otherwise appropriate form of support because national communications infrastructure cannot provide a reliable route to it. This is an area where local commissioners cannot solve the problem alone and requires national attention.

Moving beyond pilots

Pilots can establish feasibility, but repeated small scale testing does little to answer the questions that matter most: whether a model can be sustained, what it costs once embedded, how practice changes over time, and whether outcomes persist at scale.

A more mature approach would treat sustainability as an entry condition. New investment should have a defined problem to solve, a service model, ownership beyond the pilot period, an identified route to recurrent funding and an evaluation proportionate to the claims being tested. Innovation would remain important, but it would sit within a managed pathway from testing to adoption rather than being treated as an outcome.

There is also a national learning opportunity. Local authorities should not have to rediscover independently the same lessons about assessment, workforce, response, procurement, connectivity and evaluation. Greater consistency around the quintuple outcomes, combined with systematic learning from mature local models, would allow evidence and implementation knowledge to travel between places while preserving local flexibility and individual choice.

Building evidence through implementation

The aim should not be to wait for perfect evidence before improving TEC, but to build evidence generation into the way TEC is designed, commissioned and delivered. The evidence review shows that we already know a considerable amount about what good TEC requires: person centred assessment, clear response pathways, workforce confidence, usable data, reliable infrastructure, leadership, commissioning and sustained implementation. The gap is that these conditions are not consistently present, and the evidence is not yet collected in a way that allows learning to build across places.

Effective deployment of TEC also depends on a stronger evidence and data framework, including both the Theory of Change and Outcomes Framework set out in Annex A. This should describe the whole TEC pathway for that deployment, not only the technology being used. It should set out who the support is for, what need or risk it is intended to address, what information the technology generates, who acts on that information, what response is available, and what outcome is expected to change. This would make it easier to test whether value comes from the device, the monitoring process, the response pathway, practitioner judgement, family support or the wider care model.

The framework should also use a broader definition of success. TEC should not be judged only by whether it produces cashable savings. Evaluation should capture outcomes that matter to people and families, including safety, reassurance, independence, control, connection and quality of life, alongside workforce impact, service use, costs and system sustainability. These outcomes should be measured consistently enough to compare learning across places, while still allowing local flexibility and individual choice.

Better evidence also depends on better routine data. TEC programmes should collect information on who is offered TEC, who takes it up, who stops using it, what alerts or insights are generated, what action follows, how quickly responses happen, and what changes over time. Where possible, this should be linked to survey data on the experience of all the participants in the programme as well as social care, ambulance, hospital, workforce and cost data, so that outcomes can be followed across the whole pathway rather than inferred from installation or activity alone.

Economic evaluation needs the same precision. Future work should distinguish between cashable savings, avoided costs, deferred costs, released capacity, productivity gains, change in wellbeing and wider social value. It should also include the full cost of TEC, including assessment, installation, training, connectivity, monitoring, response, maintenance, data governance, review and replacement. This would help avoid both overstating benefits and undercounting the work needed to make TEC effective.

Finally, evidence generation should be built into implementation from the start. New TEC programmes should have a clear problem to solve, a defined service model, baseline data, proportionate comparators, follow up over time and a plan for sharing learning. This would help the sector address repeated short term piloting and move towards a more cumulative evidence base.

The destination is not simply more TEC. It is better and more equitable TEC, embedded in everyday care and support, and judged by the difference it makes to people's lives, people's experience of care, the workforce and the sustainability of the system (the quintuple outcomes framework).

The next phase comprises establishing a standard process for the evaluation of TEC deployment, aligned with HM Treasury Green and Magenta book methodology. It is proposed to use the TSA's Outcomes Framework as the destination and Colligo Labs' Theory of Change as the framework. The output answers two questions: where do the costs and benefits of TEC arise across health and social care and the wider public sector, especially where one part of the system invests and another benefits, and which groups of people at which stages of the care journey gain most.

Before go-live, the key stakeholders for each TEC deployment need to be identified and joint project governance process agreed. The stakeholders are likely to include local authority and NHS commissioners, representatives from their data and finance departments as well as the technology and care providers and people who draw on care and their carers. The stakeholders should agree the Theory of Change including outcomes against the Quintuple Aim. This identifies the evidence needed, suitable comparators and the risks to both the deployment and data collection. During deployment, a minimum dataset should be collected and linked from a baseline through 12 to 36 months. The data will draw on Local Authority and NHS records, the care and technology providers data and surveys of the people using the service to establish wellbeing improvements. Value is then calculated with the appropriate adjustments for counterfactual, deadweight, attribution, displacement and discounting as per HM Treasury methodology. It will be reported as a plausible value range, split across all the various beneficiaries in terms of the various public sector budget holders (Local Authority, NHS, housing, DWP and MoJ) as well as the individuals and private sector.

Annex D – What we mean by TEC: a simple model and taxonomy

Technology enabled care is described in many different ways across policy, research and practice. Even within the sector, the same technology can be called telecare, assistive technology, care technology or the name of a local service. This annex sets out what TSA means by technology enabled care (TEC), using one simple model, and explains the terms used throughout this briefing.

The model is intended to be used consistently across TSA's work, including training, guidance and communications. Terms used in the briefing are explained in section D5.

D1. Our definition

What we mean by TEC

The definition used in this briefing: ***"Technology enabled care (TEC) is the use of technology, together with the services and interventions around it, to support adults' health, wellbeing, safety and independence."***

In plain English: TEC is technology at home or out and about, from a pendant alarm or a sensor to a smartwatch, phone or smart speaker, joined up with the people and services who respond, so that people can live safely, well and independently, in the way they choose.

In people's own words: "The everyday help we need, to enjoy the lives we want" (TSA #EverydayTEC).



Four things are central to this definition:

- **It is about people, not devices.** TEC starts with what matters to the person and their family, not with a product.
- **The technology is not the intervention on its own.** TEC is the technology together with the response around it: who receives the information, who acts, and how. A device with no one to respond delivers little benefit.
- **It covers everyday and specialist technology.** From mainstream devices people already own, such as phones and smart speakers, to specialist alarms, sensors and monitoring platforms.
- **It can be reactive or proactive.** TEC can respond once something has happened, or use information to spot changes and act earlier (see Part 4 of the model).

What TEC is not, for this briefing. General digital infrastructure, such as digital care records, broadband or data systems, is not TEC on its own, although it is an essential enabler. Nor is TEC a replacement for human care: it should add to the support people receive, not take it away.

D2. The TEC model

The model below shows TEC in one picture. It has four parts, which build outwards from the person.

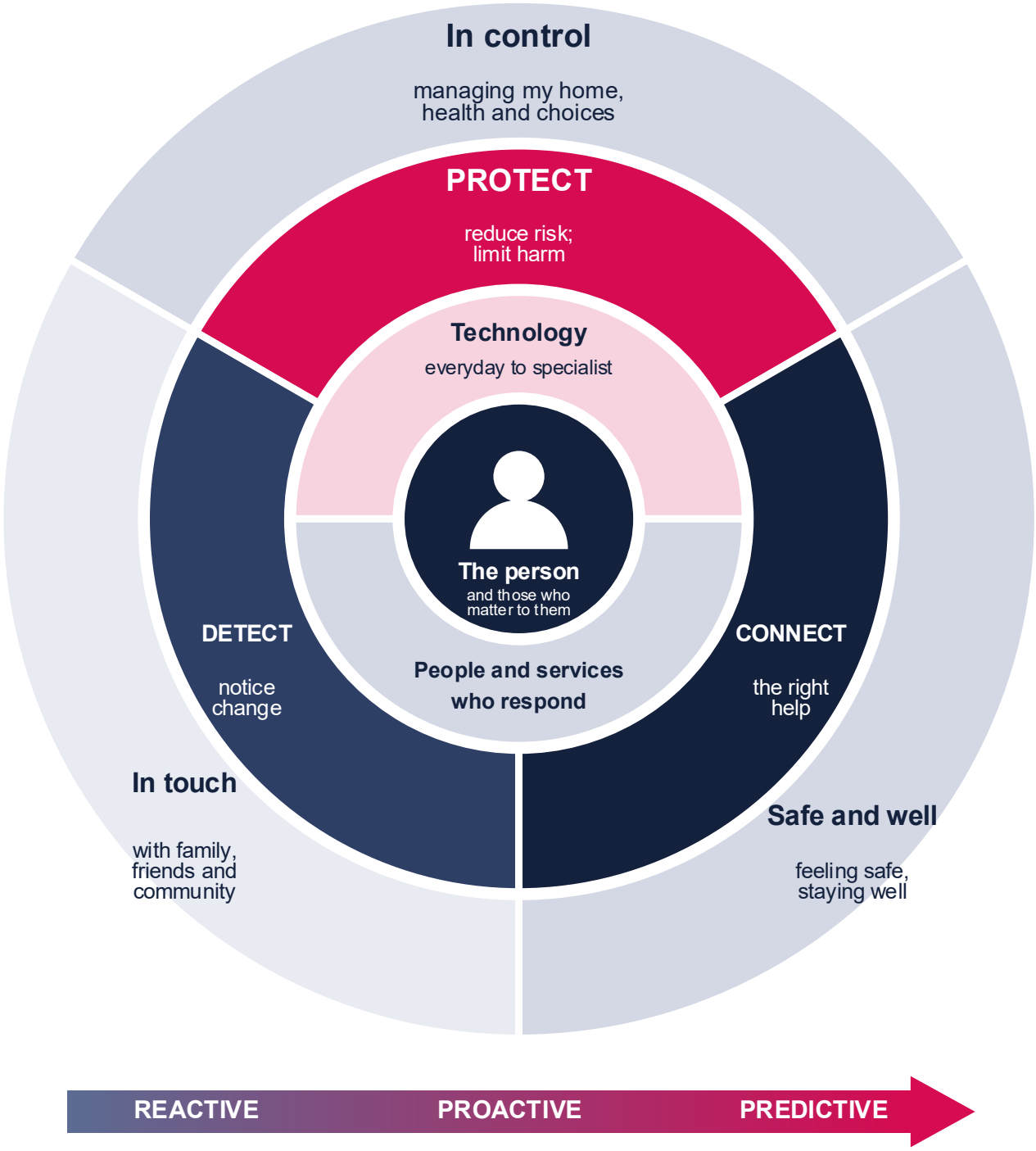


Figure D1: What we mean by TEC. The person at the centre, the technology and the people and services who respond (Part 1), how TEC works: Protect, Detect, Connect (Part 2), what it helps people achieve: In control, In touch, Safe and well (Part 3), and how it is used, from reactive to proactive and predictive (Part 4).

Part 1. What TEC is: the person, the technology and the people who respond

At the centre is the person, and the people who matter to them. Around them are two things that only work together: the technology, and the people and services who respond. The people and services who respond may include:

- the person themselves, their family and unpaid carers,
- a 24/7 monitoring centre, which receives alerts and calls and arranges the right response,
- a responder service, which visits when someone needs help in person, for example after a fall without injury,
- health and care practitioners, such as social workers, occupational therapists, home care staff, GPs and community nurses,
- the TEC service that assesses, installs, maintains and reviews the technology.

Part 2. How TEC works: Protect, Detect, Connect

Protect, Detect, Connect is TSA's simple way of explaining how TEC helps. It is not a way of sorting devices: one device often does all three.

	Protect	Detect	Connect
What it means	Reducing risk before something happens, and limiting harm if it does	Noticing that something has happened, or is changing, as early as possible	Making sure the right person knows and can respond, and keeping the person in touch with others
The question it answers	"How do we stop things going wrong, or limit the harm if they do?"	"How will we know something is wrong, or about to be?"	"Who will know, and who will help?"
Examples of TEC	Automatic lighting, stove guard, key safe, medication dispenser, temperature controls, video doorbell	Fall detector, smoke, heat and flood sensors, bed and chair sensors, door sensors, activity monitoring, health readings	Pendant alarm and monitoring centre, alerts to family, video calls, responder services, family and care apps
In everyday terms	Prevention	Early warning	Getting help, and staying in touch

Example: a fall detector **detects** a fall and **connects** the person to a monitoring centre, which sends a responder. This **protects** the person by reducing the time spent on the floor and the risk of a hospital admission.

Part 3. What TEC helps people achieve: In control, In touch, Safe and well

TEC is valuable because of the difference it makes to people's lives, not because of the technology itself. TSA's #EverydayTEC campaign, based on research with people who draw on care and support (Alden, 2024), describes this in three plain language outcomes. These line up with the outcomes already used in national policy.

Outcome	What it means for the person	Examples of how TEC helps	Links to national outcomes
In control	Managing my home, my health and my own choices, with privacy and independence	Reminders and prompts, controlling lights, doors and heating, health and medication apps, key safes and video doorbells	Care Act wellbeing: control over day-to-day life. ASCOF: independence, empowerment
In touch	Staying connected with family, friends and community, and not feeling a burden	Video and voice calls, smart speakers, family apps, GPS devices for getting out and about	Care Act wellbeing: family and personal relationships. ASCOF: social connections
Safe and well	Feeling safe at home, staying well, and getting help quickly when it is needed	Pendant alarms and monitoring centres, fall detectors, home safety sensors, health and activity monitoring	Care Act wellbeing: physical and mental health, protection from abuse and neglect. ASCOF: safety, quality of life

In control, In touch, Safe and well: TSA #EverydayTEC campaign and language guide. Care Act 2014, section 1 (wellbeing principle). ASCOF: Adult Social Care Outcomes Framework (DHSC, from April 2023).

Part 4. How TEC is used: from reactive to proactive and predictive

The same technology can be used in different ways. Most services today blend reactive and proactive support.

Way of using TEC	What it means	Example
Reactive	Responds once something has happened, usually when an alarm is raised by the person or a sensor	A pendant is pressed after a fall, the monitoring centre speaks to the person and sends a responder
Proactive and preventative	Uses information from devices, and outreach to the person, to spot early signs of change and act before a crisis	Activity monitoring shows more trips to the bathroom at night, a check-in leads to a GP visit that finds an infection before it causes a fall

Way of using TEC	What it means	Example
Predictive	Uses data analysis, sometimes including artificial intelligence, to estimate risk before signs are obvious. This is emerging, and fewer than 10% of telecare services use it today	A platform flags that a person's pattern of movement suggests a rising risk of falling, so a falls assessment is offered early

TSA defines the shift in this way: a service "matures to a proactive and preventative model when it begins to use data analysis and proactive outreach to the user instead of relying solely on user generated or circumstantial occurrences" (TSA, Proactive & Preventative Services: Definitions and Guidance, 2023).

Bringing it together: an illustrative example

Joan, 84, lives alone and has had two falls this year

Protect: automatic lighting from her bed to the bathroom, and a fall detector she is happy to wear.

Detect: activity monitoring shows she is getting up far more often at night than usual.

Connect: the monitoring centre calls Joan and lets her daughter know, a referral to her GP finds a urinary infection, which is treated early.

Outcomes: Joan stays safe and well, in touch with her daughter, and in control of her own life at home.

How it is used: proactive. A change was spotted and acted on before a fall or hospital admission.

D3. Types of TEC

TEC covers a wide range of technology, and any list will change as technology develops. The families below are a guide. Many products sit in more than one family, and every family can be used reactively or proactively.

Family of TEC	Examples	Also called
Telecare	Alarm unit and pendant, pullcord, fall detector, smoke, heat, flood and temperature sensors, door, bed and chair sensors, mobile alarms with GPS	Community alarm, personal alarm, Lifeline, Careline, digital telecare
Health monitoring	Blood pressure, oxygen, weight and glucose monitors linked to an app or hub, symptom check-ins	Telehealth, remote monitoring, virtual wards
Activity and lifestyle monitoring	Passive sensors that learn daily routines, multi-sensor and radar platforms, acoustic monitoring, data dashboards	Connected care, home activity monitoring
Daily living aids	Medication dispensers and reminders, clocks and memory aids, sensory and communication aids, environmental controls	Assistive technology

Family of TEC	Examples	Also called
Everyday and smart home technology	Smart speakers and voice assistants, video doorbells, smart plugs, lights and thermostats, smartwatches, phones and tablets	Everyday TEC, smart home, consumer technology
Virtual care and communication	Video calls and consultations, wellbeing and self-management apps, family and care apps, scheduled check-in calls	Telemedicine, video consulting, digital health
Emerging technology	Artificial intelligence and predictive analytics, companion and assistive robots, virtual reality	AI, robotics, immersive technology

D4. Why TEC is called different things

There is no single, agreed definition of TEC across UK policy and research. Different terms have grown up in different sectors, nations and periods, and for different purposes:

- **Sector:** health tends to talk about telehealth, remote monitoring and virtual wards, social care about telecare and care technology, housing about alarms and warden call.
- **Nation:** the Scottish, Welsh and Northern Ireland programmes use "technology enabled care". In England, DHSC and NHS England mainly use "care technology" and "digital social care", and NICE is developing an evidence framework for "digital care technologies".
- **Purpose:** funding, regulation, procurement and evidence frameworks each group technology in their own way.
- **Local services:** in a TSA review of 212 UK Local Authority and health and social care trust websites (2026), 82% of the pages read used "telecare", 30% "technology enabled care" and 5% "care technology", and 59% of authorities presented the service under a local name such as Careline or Lifeline.

Most of these terms are not exact alternatives. They overlap but differ in how much they cover. The table shows how the main terms relate to TEC.

Term	What it usually means	Mainly used by	How it relates to TEC
Assistive technology	Any product that helps a person do things or stay independent, digital or not (from grab rails to communication aids)	WHO, ISO, Disabled Facilities Grant, many Local Authorities	Broader: includes non-digital aids
Care technology	Technology used in social care, including sensors and smart home devices, often alongside digital care records	DHSC, NHS England, some Local Authorities	Similar scope, plus tools used to run care
Digital care technologies (DCT)	Not yet defined. Examples include care planning systems, falls and monitoring sensors, digital medication systems and workforce tools	NICE (framework due spring 2027)	Broader: includes tools used to run care

Term	What it usually means	Mainly used by	How it relates to TEC
Digital social care	Digitising the care system, especially digital care records and connectivity	DHSC, NHS England	An enabler of TEC, not TEC itself
Telecare	Alarms and sensors at home linked to a 24/7 monitoring centre and response	Most Local Authorities and housing providers	Part of TEC, the most established form
Community or personal alarm	A pendant or alarm unit with a 24/7 response, often a local brand	Local Authorities, housing providers, government	The core of telecare
Telehealth / remote monitoring	Health readings monitored remotely by health professionals	NHS, Wales, Northern Ireland	Part of TEC, on the health side
Virtual wards / Hospital at Home	Hospital-level care at home, often supported by remote monitoring	NHS	An NHS service model that uses TEC
Connected care	Using data from several devices together to spot changes early	TSA, suppliers, some Local Authorities	A proactive way of using TEC
Everyday TEC / smart home	Mainstream consumer devices used to support care and independence	TSA, DHSC, Disabled Facilities Grant	Part of TEC
TECS (technology enabled care services)	Earlier NHS England term covering telehealth, telecare, telemedicine, telecoaching and self-care apps	NHS England (2015), NHS procurement	Earlier name for TEC

D5. Glossary of terms used in this briefing

Terms are grouped by theme. Where a term has a formal or legal meaning, the plain-English explanation here is a summary and does not replace it.

TEC and how it is delivered

Term	What it means
Technology enabled care (TEC)	The use of technology, together with the services and interventions around it, to support adults' health, wellbeing, safety and independence (see D1).
Telecare	An alarm unit and sensors in the home, linked 24 hours a day to a monitoring centre that arranges the right response, such as a call to family, a responder visit or an ambulance.

Term	What it means
Pendant / personal alarm	A button worn around the neck or wrist that the person presses to call for help.
Sensor	A device that notices an event or a change, such as a fall, smoke, flood, extreme temperature, a door opening or someone leaving their bed.
Alert	A signal sent when a device is triggered, either by the person pressing a button or automatically by a sensor.
Monitoring centre (Alarm Receiving Centre, ARC)	A 24/7 centre that receives alerts and calls, speaks to the person and arranges the right response.
Responder service	A team that visits the person when help is needed in person, for example to help someone up after a fall without injury, often avoiding the need for an ambulance.
Telehealth / remote monitoring	Health readings (such as blood pressure, oxygen or glucose) taken at home and reviewed remotely by health professionals.
Activity or lifestyle monitoring	Sensors that learn a person's usual daily routine and flag meaningful changes, such as disturbed sleep or not eating.
Connected care platform	Software that brings together information from several devices to show patterns and send alerts or insights to the people who need them.
Wearable	A device worn on the body, such as a smartwatch, fall detector or GPS tracker.
Everyday TEC	Mainstream technology many people already own, such as smartphones, tablets, smart speakers and video doorbells, used to support care and independence.
Predictive analytics	Using data, sometimes with artificial intelligence, to estimate the likelihood of a future event, such as a fall, before signs are obvious.
Interoperability	The ability of devices and systems from different suppliers to work together and share information.
Analogue to digital (digital switchover)	The national replacement of copper telephone lines with digital (interne based) lines. Telecare that relied on analogue lines has had to move to digital equipment.
Care technologist	A role category in the national Care Workforce Pathway for people who help others choose and use care technology.

Ways of using TEC and care pathways

Term	What it means
Reactive TEC	Technology and associated activity used to detect, communicate or respond to an event once it has occurred.
Proactive and preventative TEC	Using technology, data and proactive intervention to identify emerging needs or risks and act earlier, to prevent, reduce or delay the need for more support.
Prevention (prevent, reduce, delay)	The Care Act 2014 duty on Local Authorities to prevent, reduce or delay people's need for care and support.
Front door / pre-front door	The front door is a person's first contact with adult social care. Pre-front door means support offered before that contact, for example through community, health or voluntary services.
Eligibility threshold	The national criteria (under the Care Act) that decide whether a person qualifies for Local Authority funded care and support.
Trusted assessor	A trained member of staff, often outside the social care team, who is authorised to assess for and order TEC directly.
Right sizing	Adjusting a care package so it matches the support a person actually needs, often using evidence from short term monitoring.
Reablement	Short term support, usually for up to six weeks, that helps a person regain skills and confidence after illness or a hospital stay.
Discharge to assess (D2A)	Supporting people home from hospital as soon as they are well enough, and assessing their longer term needs at home rather than in hospital.
Wellbeing calls	Scheduled outbound calls, by a person or an automated voice service, to check on someone's wellbeing.
Self-funder	A person who arranges and pays for their own care and support, including TEC.
Unpaid carer	A family member, friend or neighbour who provides care and support without being paid.

Policy and system reform

Term	What it means
Casey Commission	The independent commission on adult social care in England, led by Baroness Louise Casey, whose work will inform the development of a National Care Service.
National Care Service	The Government's planned future model for adult social care in England, which the Prime Minister has said "starts in the home".
10 Year Health Plan	The Government's plan for the NHS in England (2025), built around three shifts: hospital to community, analogue to digital, and sickness to prevention.
Neighbourhood health	Bringing health and care services together at a local level, so people receive more joined-up care closer to or at home.
Single Patient Record	A planned single, shared record of a person's health information, intended to support more joined-up and proactive care.
Modern Service Frameworks	National NHS frameworks setting out expected models of care for particular conditions or groups, such as frailty.
Care Act 2014	The main law for adult social care in England, including the wellbeing principle and the duty to prevent, reduce or delay needs.
Care Workforce Pathway	The national career framework for the adult social care workforce in England.

Funding and commissioning

Term	What it means
Commissioning	How Local Authorities and the NHS plan, buy and monitor services to meet the needs of their population.
Better Care Fund (BCF)	A pooled budget between the NHS and local authorities to support joined-up health and social care.
Disabled Facilities Grant (DFG)	A capital grant for home adaptations, guidance allows it to fund telecare and assistive technology where the cost is capital.
Cashable saving	Money that can actually be removed from a budget as a result of a change.
Cost avoidance	Costs that would otherwise have been incurred, such as an ambulance call out or a care home placement, but were avoided or delayed.
Released capacity	Staff time freed up by a change. It is valuable, but is not automatically a cash saving.

Term	What it means
Prevention funding paradox	When the organisation that pays for prevention is not the one that receives most of the benefit, so the investment is hard to justify for a single budget.
LG Inform	The Local Government Association's online data service, used to compare information about Local Authorities.

Evidence and evaluation

Term	What it means
Theory of Change	A step-by-step explanation of how and why an intervention is expected to lead to its intended outcomes.
Quintuple Aim	The five aims in TSA's Outcomes Framework: equity of access, quality of life and health outcomes, people's experience of care, workforce experience, productivity, efficiency and sustainability.
ASCOF	The Adult Social Care Outcomes Framework: DHSC's national measures of how well adult social care is achieving outcomes for people.
Making it Real	Think Local Act Personal's "I" and "We" statements describing what good, personalised care and support looks like.
Green Book and Magenta Book	HM Treasury guidance on appraising options before investment (Green Book) and evaluating what happened after (Magenta Book).
Social Return on Investment (SROI)	A method of valuing the social, economic and wellbeing outcomes of an activity, often expressed in money terms.
Describe, Compare, Contribute	The evidence "ladder" used in this briefing: describing what was delivered, comparing against a baseline, and estimating how much of a change TEC plausibly contributed.

Sources: TSA (2023) Proactive & Preventative Services: Definitions and Guidance, TSA #EverydayTEC campaign and language guide, TSA (2026) Types and Categories of TEC: evidence review (including a scan of 212 UK Local Authority and trust websites), NHS England (2015) Technology Enabled Care Services, NICE (2026) Evidence standards framework for digital care technologies, Care Act 2014, DHSC ASCOF (2023), DHSC (2025) 10 Year Health Plan.

Annex E – Common uses of proactive and preventative TEC

Prevention is the area where there is widest agreement that TEC should help, and where the evidence is still emerging. But proactive and preventative TEC is not new or theoretical. Many Local Authorities already use it routinely, for thousands of people. This annex sets out eight common uses, with examples of where they are already in place.

Examples are drawn from TSA's Blueprint interviews with 13 local authorities and 7 TEC suppliers (2026), TSA's Proactive & Preventative Services Overview, and case studies shared with TSA. Figures are as reported by the organisations concerned and have not been independently verified unless stated. Figures still awaiting independent review are not included.

	Use	What it does	Examples
1	At the front door	Helps people with lower level needs to support themselves with TEC, before or instead of formal care	Essex
2	Assessment and reassessment	Uses short term monitoring to understand real needs and right size care	West Sussex, Stockton-on-Tees
3	Reablement and hospital discharge	Supports people home from hospital and informs longer term needs	Stockton-on-Tees, Essex
4	Remote care	Adds virtual check-ins and monitoring alongside, or instead of, some visits	London Borough of Sutton
5	Long term care at home	Continuous monitoring to spot gradual changes early	Warwickshire, Derwen College
6	Falls prevention and response	Reduces risk of falls, and responds quickly without an ambulance where safe	Mole Valley (Surrey), Worcestershire, North Somerset
7	Wellbeing calls	Scheduled check-ins to spot deterioration and reduce isolation	Hartlepool, Croydon
8	Medication support	Reminders and prompts so people take medicines safely and on time	Staffordshire, Hampshire

E1. At the front door: helping people support themselves

What it is. Many people who contact adult social care do not meet the eligibility threshold, but still want to do something to stay independent. In 2024/25 there were 1.39 million new requests for support in England. TEC at, and before, the front door gives people information, simple self-assessment and help to choose TEC they can use or buy themselves. This prevents needs escalating into more costly support later.

How it works. Protect and Connect: advice and low-level TEC put in place early, often by trained staff outside social care, with signposting to self-funded options.

Where it is already happening.

- **Essex County Local Authority** trains staff across primary care, community health, hospital, dementia and reablement teams as "trusted assessors" who can order TEC directly. Essex reported over 1,100 external staff trained, monthly orders rising from around 200 to over 1,000, and more than 21,000 people supported. Around 95% of people in this pathway remained outside formal social care, and only 8–9% entered social care within six months. Essex modelled charging for TEC and decided not to, because lower uptake was projected to increase future demand for care.

Also in use in: Somerset (a direct-to-consumer model, at an early stage).

E2. Assessment and reassessment: understanding real needs

What it is. Sensors are placed in a person's home for a short period, typically up to 30 days, to build an accurate picture of how they manage daily living. This helps practitioners make better-informed decisions, right size care packages, and identify needs that were previously hidden.

How it works. Detect: activity data shows real routines. Connect: insights go to the social worker or occupational therapist. Protect: the right level of support is put in place.

Where it is already happening.

- **West Sussex** (NRS Healthcare and Howz, 2025): monitoring for a woman living with dementia, supported by her husband, showed the couple were managing well with existing support, so the care package did not need to change. The social worker's aim was to delay a care home admission by at least 12 months, with potential cost avoidance estimated at £52,264 a year.
- **Stockton-on-Tees** uses a "TEC First" referral and outcomes form, with savings tracked by finance staff. They net off replacement care costs and client contributions, and reverse a recorded saving if the outcome does not hold.

Also in use in: Cornwall, Mole Valley, London Borough of Sutton, Redcar and Cleveland.

E3. Reablement, discharge to assess and post-discharge support

What it is. People leaving hospital are supported at home with activity monitoring, smart speakers and check-ins during reablement. This builds confidence, spots problems early to avoid readmission, and gives evidence about the support they will need longer term.

How it works. Detect: changes in daily activity during recovery. Connect: alerts and check-ins to the reablement team and family. Protect: support adjusted quickly.

Where it is already happening.

- **Stockton-on-Tees** has redesigned its hospital front door, building TEC into discharge pathways under a formal programme structure.
- **Essex County Local Authority** trains reablement and home-to-assess teams to prescribe TEC directly.

Also in use in: Buckinghamshire, Leicestershire (Leicester, Leicestershire and Rutland ICB), Lincolnshire, Cumberland, Dumfries and Galloway.

E4. Remote care

What it is. Virtual check-ins, video calls, smart speakers and behavioural monitoring support people early in their care journey, alongside or instead of some in-person visits. Staff time is focused where it is most needed.

How it works. Detect: a personal baseline flags changes by exception. Connect: the care team and family are alerted. Protect: support is stepped up before a crisis.

Where it is already happening.

- **London Borough of Sutton** (with Medequip) reported 689 people using proactive TEC since 2023, as well as 509 supported-living properties. The platform builds each person's behavioural baseline within 30 days and alerts by exception. In one example, two people with learning disabilities avoided an estimated £96,000 a year in combined care costs.

Also in use in: Telford and Wrekin, Cumberland, Dumfries and Galloway.

E5. Long term care at home and in supported settings

What it is. Continuous monitoring, including multi-sensor platforms and acoustic monitoring, helps people with long term conditions, dementia or learning disabilities by spotting gradual changes in sleep, eating, toileting or activity. Staff respond to need rather than routine checks.

How it works. Detect: patterns and changes over time. Connect: alerts to staff only when thresholds are reached. Protect: earlier support, and fewer disruptive night checks.

Where it is already happening.

- **Warwickshire** (Adaptive Care and Quantum Care): two staff monitor more than 300 care home residents using centralised acoustic and visual monitoring. The arrangement continued on a commercial basis after a one-year ICB-funded trial.
- **Derwen College** (residential support for young people with learning disabilities): after acoustic monitoring was introduced, physical night-time checks fell from an average of 17 a night to 3 a night over eight months, with more settled sleep for residents.

Also in use in: Leeds, London Borough of Redbridge, Leicestershire, Lincolnshire, Shropshire.

E6. Falls prevention and response

What it is. TEC reduces the risk of falling, detects falls quickly, and enables a fast response, often from a responder service rather than an ambulance when the person is not injured.

How it works. Protect: lighting, sensors and falls assessment. Detect: fall detectors and changes in activity that signal rising risk. Connect: monitoring centres and responders who can lift people safely.

Where it is already happening.

- **Mole Valley District Local Authority** (for Surrey County Local Authority) runs a community responder and connected care service handling around 250 incidents a month, with around £1 million of reported cost avoidance.
- **Worcestershire** (with Taking Care) has an externally developed business case that values each avoided ambulance call-out at £450.
- **North Somerset** Response 24 is a community responder service that has supported around 980 people for 15 years, funded through the Better Care Fund.

Also in use in: Lancashire, Essex.

E7. Outbound wellbeing calls

What it is. Scheduled calls from a monitoring centre, or an automated voice service, check on people's wellbeing, hydration and medication. They help spot deterioration early and reduce loneliness, particularly where short care visits are hard to provide.

How it works. Connect: regular contact. Detect: early signs of decline. Protect: earlier support, and escalation where needed.

Where it is already happening.

- **Hartlepool** (with Taking Care) runs an established, multi-stage wellbeing call and risk-stratification service.

Also in use in: Cumberland, London Borough of Sutton, Stockton-on-Tees.

E8. Medication support

What it is. Smart speakers, apps and automated dispensers remind people to take their medicines safely and on time, and can alert someone if a dose is missed. Most current use is reminders, more advanced medication management is not yet in routine use.

How it works. Protect: reminders and dispensers. Detect: missed doses. Connect: alerts to family, carers or the care team.

Where it is already happening.

- **Hampshire and Staffordshire** have scaled voice-assistant technology (Vocalla) that can provide reminders and wellbeing check-ins.

Also in use in: Telford and Wrekin, Norfolk, Lincolnshire, Leicestershire, Sunderland.

What these uses have in common

- They are already in use by many Local Authorities, for thousands of people, not only in pilots.
- They all depend on the response, not just the technology: someone must receive the information and have the time and role to act on it.
- The strength of evidence varies between uses and there is no consistent measure. In TSA's interviews, the most developed local evidence was for front door prevention, falls response and right-sizing care, which makes them good places to build the national evidence base.

Sources: TSA (2026) Blueprint V2 Interview Synthesis, TSA Proactive & Preventative Services Overview, NRS Healthcare and Howz case study (West Sussex, February 2025), Derwen College acoustic monitoring case study, Essex County Local Authority TEC service overview.

Annex F - 10 principles for building stronger TEC evidence

Developed for TSA by the Social Care Institute for Excellence (SCIE), working alongside Colligo Labs, these principles draw on the project's structured evidence review and sector engagement work. They bring together the key lessons from the existing evidence base and identify practical steps that commissioners, providers and suppliers can take to strengthen future evaluation.

The review found valuable evidence of TEC's implementation, acceptability, perceived benefits and impact in specific care pathways. However, recurring limitations include inconsistent definitions, short evaluation periods, limited comparative evidence and insufficient measurement of longer term outcomes, workforce effects and economic value.

The aim is not to wait for perfect evidence, but to make the collection of credible, consistent and meaningful evidence a routine part of TEC delivery.

The ten principles for better evidence:

1. **Clearly define the technology and the care pathway being evaluated.** Describe what technology is being used, its purpose and functionality, who it is intended to support, and the wider service model around it. This should include assessment, installation, monitoring, response and ongoing review. Use consistent terminology and establish a clear Theory of Change explaining how the complete intervention is expected to improve outcomes.
2. **Plan evaluation from the outset**. Agree what success looks like before implementation, establish baseline information and, wherever possible, identify an appropriate comparison group or existing service model. This helps distinguish changes associated with TEC from improvements that may have happened anyway.
3. **Capture outcomes that matter to people.** Look beyond service activity and financial savings. Include safety, independence, reassurance, choice, control, social connection and quality of life. Use consistent, established approaches where appropriate, alongside people's own accounts of their experiences and what has changed for them.
4. **Follow the journey from information to action**. Record what information TEC generates, who receives and interprets it, what response follows and whether this changes someone's care or circumstances. Installation numbers, alerts and activity alone do not demonstrate better outcomes. Earlier identification only becomes prevention when it leads to an effective response.
5. **Follow outcomes over longer periods**. Move beyond short term pilots to understand whether benefits are sustained, needs change, escalation is delayed and services remain effective over time. Where feasible and appropriate, connect TEC information with wider health and social care data to understand longer term outcomes.
6. **Understand what works, for whom and under what circumstances**. Capture relevant information about people's needs, characteristics, care settings and stages of their care journeys. Examine differences in who is offered TEC, who takes it up and who benefits, including whether inequalities in access or outcomes persist.
7. **Report what does not work, as well as what does**. Record non-use, abandonment, technical failures, unintended consequences and potential harms, including any loss of

valued human contact. Understanding why an intervention is unsuitable or unsuccessful is essential to improving future services.

8. **Capture the full impact on the workforce and unpaid carers**. Assess whether TEC releases capacity, changes working practices or creates additional responsibilities. Include the time required for assessment, training, monitoring, interpretation, troubleshooting and response, rather than assuming that introducing technology automatically reduces workload.
9. **Account for the full costs and different forms of value**. Include the costs of delivering and maintaining the complete TEC service, not just purchasing equipment. Distinguish between cashable savings, avoided or deferred costs, released capacity and wider social value. Identify which organisations incur costs and where the benefits are realised across health and social care.
10. **Build independence, transparency and consistency into evaluation.** Use independent evaluation wherever possible, agree common definitions and approaches, and report positive, mixed, negative and inconclusive findings. Make methods, assumptions and limitations clear, and share learning so that evidence can accumulate across organisations rather than remaining within individual projects or suppliers.

Annex G - References

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