# Care services. The work around the care.

A guide to planning software for coordination, records and scheduling in adult social care, and to the boundary it should not cross.

# A guide to the administration, not the care.

Adult social care has spent five years being asked to go digital, and has very largely done it. This guide is about what to plan next, written for the people who will have to live with the answer.

Every figure in it is traced back to the body that published it. The technology moves quickly enough that none of the evidence here predates 2025.

Written for registered managers, operations leads, and the people who choose and pay for their systems.

CONTENTS



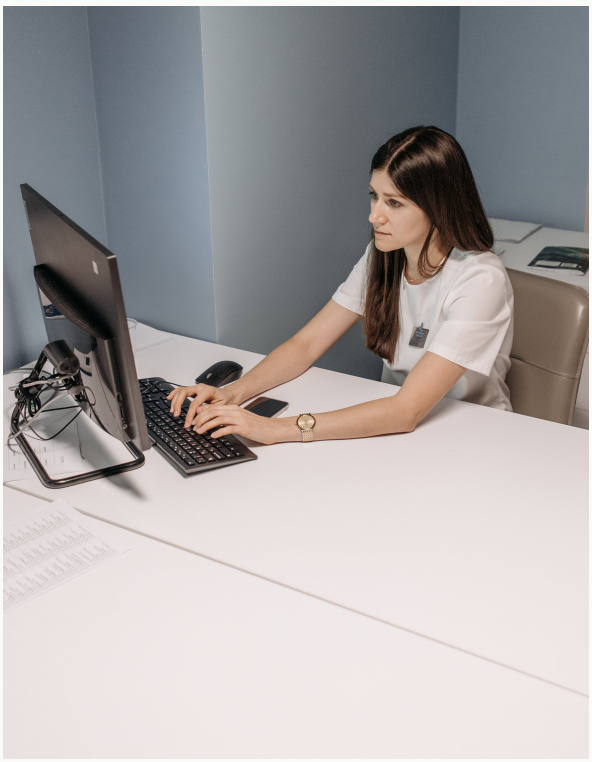
## What this guide is not

It is not clinical advice, and it contains none. Every workflow described here is administrative. Where a decision belongs to an accountable professional, the guide says so and stops.

It is not a case study. No care provider is described, named or implied, and the photographs are illustrative. It makes no claim that any software improves care, because the published evidence does not support one.

It is not a product comparison. BespokeWorks builds software, and readers should weigh the guide accordingly. The questions on page 12 are as useful against our work as against anyone else's.

# What was never measured.



In June 2026 an estimated 83.6 per cent of registered adult social care locations in England held a digital care record, against 79.3 per cent a year earlier. The department that publishes the figure is careful about it: providers report on themselves, and each reading covers roughly a twelfth of the market on a rolling basis rather than counting it. The direction is not in doubt. The sector has gone digital.

What was never established is what it was worth.

The Department of Health and Social Care estimates that digital records will save thirty million administrative hours a year, and give back at least twenty minutes per care worker per shift. Both figures appear in a press release of 5 December 2025 and are repeated on the programme's own website. The release gives no method for either figure, and cites nothing.

The largest independent evaluation of the programme reports a genuinely mixed picture, and it leads with the good part. Funded by the National Institute for Health and Care Research and published in May 2026, it found that adoption had saved time and delivered other benefits, while experiences varied widely. Providers described records that were legible, instantly available and far harder to lose than paper.

The same study records the other side. Suppliers estimated around eight hours to input a single record during migration. One office manager spent two extra hours a day on tasks that filled gaps care staff could not fill during visits. Paper ran alongside the system. At least one home care provider planned to abandon its software as soon as the contract allowed.

It is a qualitative study, across thirty providers in four areas, and it did not measure time. It could not have. Nobody has ever measured how much time care and care-office staff in England spend on administration, so there is no baseline to measure against.

# What the figures record.

The adoption figures are official statistics and they are carefully caveated by the people who publish them. The caveats matter more than usual, because these numbers are doing work in procurement conversations.

The headline comes from the Provider Information Return, a mandatory annual submission made on the anniversary of registration. Roughly a twelfth of the market refreshes in any given month, the published reading covers a rolling three-month window, and providers report on themselves. The release warns that its proportions cannot be added together, and that locations and people are separate counts of different things.

SELF-REPORTED ADOPTION

**83.6%**
Of registered locations held a digital care record, June 2026

**73%**
Of providers used one when surveyed, February to March 2025

**63%**
Of providers used digital rostering in that same survey

**27%**
Of providers used no care technology at all

The survey behind the last three figures records what providers said stops them. Set-up cost was named by 73 per cent and ongoing licence cost by 70 per cent, ahead of training, connectivity and staff reluctance. Forty per cent asked for inspection guidance and regulation, which is an unusual thing for a sector to request and worth reading twice. It is a voluntary survey of 1,085 providers, and its publisher states plainly that it should not be used to plan for the sector as a whole.

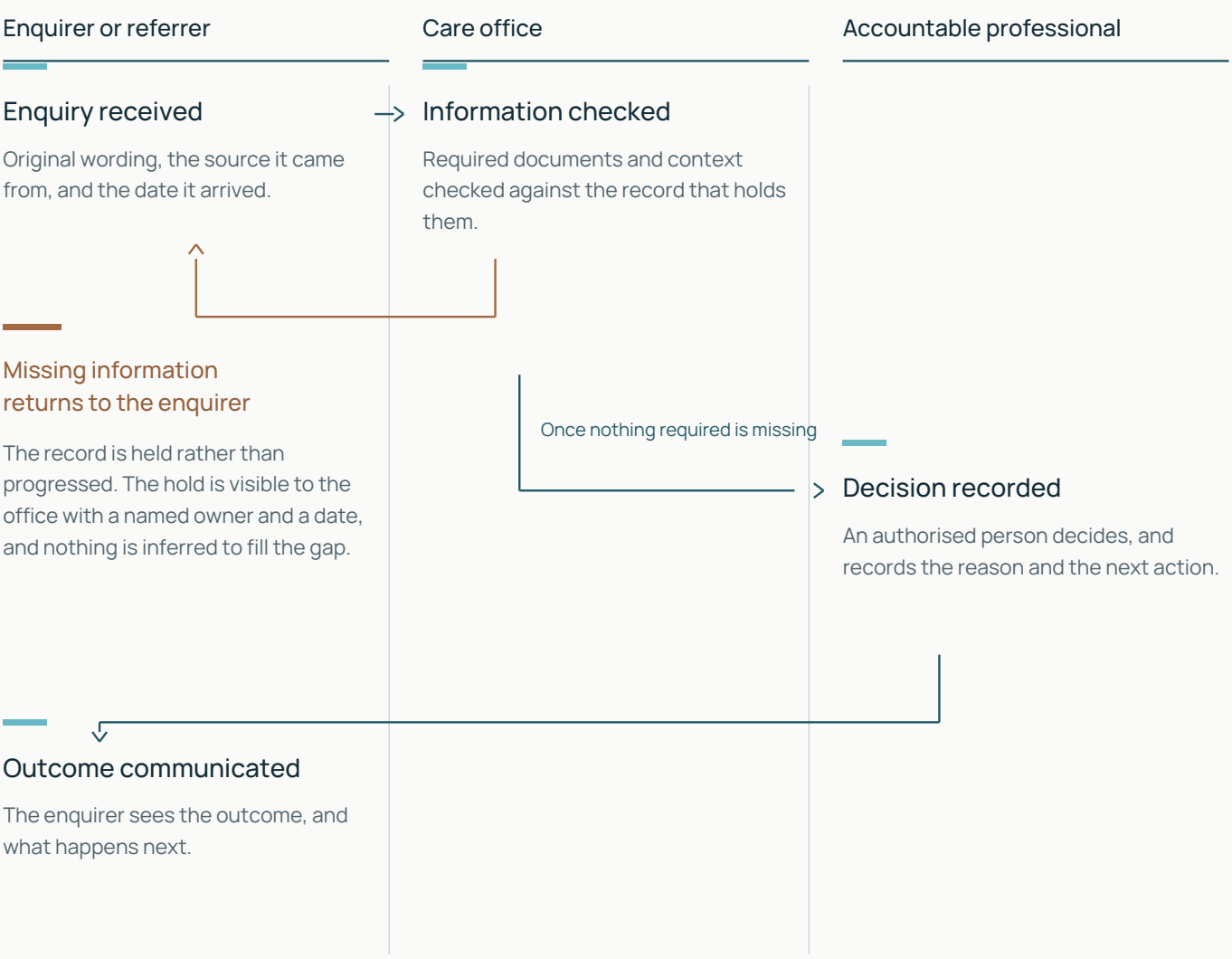
Size separates this market more than anything else does. Digital rostering reaches 81 per cent of large providers and 52 per cent of micro ones. Any plan that assumes a small provider can absorb the same change as a group is planning for a different sector.

> A provider can be recorded as fully digitised without anyone having established what being digitised was worth.

# A referral, and where it stops.

A blueprint earns its place when it exposes a dependency. This fictional enquiry follows one shared record through an office, including the route it takes back when something required is missing. The last step is deliberately outside the software.

ILLUSTRATIVE SERVICE BLUEPRINT




Design implication

A shared status is useful only when it names who acts next, and what they are waiting for.

# Where the boundary sits.

The Care Quality Commission does not assess or approve particular technologies, and says so. It maps them onto regulations that already exist. Its page on artificial intelligence, last updated on 21 May 2026, sets out eleven principles for providers using it, the first being that such systems can enhance human decision making but not replace it.

The commission also names a risk that suppliers rarely do: that artificial intelligence and the human oversight it requires can increase workload. It lists the tendency of these systems to present untrue information authoritatively as fact, and the de-skilling of people who come to rely on them.

| Regulation | What it requires | Where software meets it |
|---|---|---|
| Regulation 9 | Care designed around the person, with their involvement in decisions about it. | A system that records only the outcome of a decision does not evidence that the person was part of it. |
| Regulation 11 | Consent obtained from the person, or under lawful authority where they cannot give it. | A field that arrives pre-ticked is not consent. Record who gave it, when, and on what basis. |
| Regulation 12 | Safe care and treatment, including that equipment is safe. The commission names artificial intelligence here. | Anything that infers rather than records needs a stated failure mode and a named person who reviews it. |
| Regulation 17 | Good governance: records that are accurate, complete, contemporaneous and securely kept. | This is the records regulation. It does not require records to be electronic. |

Nothing in the regulations requires a digital record. The commission's own guidance states that paper and electronic records are both acceptable where they meet the Data Protection Act 2018.

# What scheduling data is for.

Rostering and electronic call monitoring are the most established technologies in home care and the least evaluated. No United Kingdom effectiveness study of electronic call monitoring could be found. Nothing has been trialled, and nothing measured before and after. What exists is guidance on visit length, local business cases asserting savings.

The economics are published, and they are counter-intuitive. The Homecare Association puts the minimum price for England in 2025 to 2026 at £32.14 an hour. Broken down by visit length, a fifteen-minute call prices far above that and a full hour below it, because travel forms a much larger share of a short visit.

MINIMUM PRICE PER HOUR, BY VISIT LENGTH


Homecare Association, A Minimum Price for Homecare April 2025 to March 2026, published December 2024, modelled at the National Living Wage. Variants of the £32.14 headline rate, not four separate prices. Sector body modelling, not an official statistic.

A council auditing its own home care contract found what follows from treating this data as a payment instrument. Reported to its audit committee on 21 November 2025, the audit gave partial assurance, rated provider data integrity a red risk, and found that visit data fed from call monitoring and provider rostering systems showed integrity problems serious enough to need manual workarounds, across some 150,000 lines of data every four weeks.

The only national position found on the question recommends the opposite of what most contracts do: the Homecare Association advises commissioners to pay in advance on planned hours rather than in arrears on actual time. No government body requires payment on actual time, and the commission does not require call monitoring at all.

# What a care record can reach.

The part providers ask about most is the join with the health service, and it is where published ambition and published capability sit furthest apart. A care record can read a little. It cannot write.

| Route | The position in September 2026 | What to plan around |
|---|---|---|
| GP Connect | Read only. In a care home, non-clinical staff in eligible roles see a filtered summary: allergies and adverse reactions, medications, immunisations, and notes on the last three encounters with their GP. Clinical staff employed by the provider see the fuller record. | Requires an assured record system, the data security toolkit at standards met, and a signed national data sharing arrangement. No agreement with individual practices is needed. |
| Writing back | Not available. The update capability has been assured only between community pharmacy and general practice. A send-document capability for care services is described as planned, with no published date. | Assume that what a care team learns reaches the practice by telephone, secure email or not at all. |
| Proxy access | The one transactional route open today, and a different thing from GP Connect. Care home staff can book appointments and order medication with a note to the practice. | Local rather than national: explicit consent from each person, an agreement and an impact assessment with each practice, and care homes only. |
| The single patient record | Adult social care sits outside the initial scope. The department's own impact assessment says it will cover primary and secondary care first, expanding over time to services such as adult social care. | Commitments run to 2028 and 2030 and depend on legislation still before Parliament. Plan as though it will not arrive inside this procurement cycle. |

Two government sources describe that filtered view differently. The health service's page, last edited on 3 September 2026, lists the four items above for the care home view. The department's press release of 5 December 2025 lists seven, adding active concerns and medical history, test results and referrals, which is the broader summary rather than the filtered one. Both are still published. Ask a supplier which of the two it built to.

# Established, asserted and sold.

Four kinds of claim circulate in this sector at once and they are not the same kind of thing. The two on this page are the ones a provider can rely on. The two overleaf are the ones to ask questions about.

## Established

Regulators have published expectations. The Care Quality Commission set out eleven principles for artificial intelligence on a page last updated in May 2026. The health service published requirements for ambient scribing products, updated in July 2026, including a mandatory impact assessment before deployment.

The Information Commissioner has advised that explicit consent is unlikely to be appropriate for artificial intelligence cameras in care home bedrooms. Its reasoning turns on staff and visitors as much as residents: a resident can refuse and have the camera switched off, but everyone entering that room would also have to agree.

## Evaluated, but not here

Artificial intelligence used to draft social work assessments has been evaluated, and the results are substantial. An independent evaluation of a test in Kent County Council, published in January 2026, reported an average reduction of 2.7 hours per assessment, close to half. Alan Turing Institute researchers reported the same direction across three councils with 91 staff.

Those studies evaluate local authority social work assessment, not provider administration, and they are commissioned evaluations rather than peer-reviewed ones. They are real evidence about a different job.

# Asserted, and sold.

These are the claims most often made in a sales conversation, and the ones least often accompanied by anything a buyer could check.

## Not established

That those results transfer to a care provider's office, where the work, the records and the accountabilities are different.

That digital records save administrative time. The government estimate carries no method, and the evaluation that exists did not measure time.

That electronic call monitoring improves anything beyond billing. No United Kingdom effectiveness evaluation of it could be found.

## Self-reported

The quantified benefit claims on the health service's own artificial intelligence case study page for adult social care are reported by the provider or supplier making them. Nothing on that page has been independently evaluated, and none of it carries a figure for time saved or for accuracy.

Unverified is not the same as false. It is a reason to ask for the workings, and to write the answer into the contract.

# What a small pilot needs to show.

Agree the evidence before building anything. A pilot is useful when it makes its own limitations observable, so a team can decide to refine it, stop it or extend it on something other than enthusiasm.

| Question | What to observe | Accountable role | Release condition |
|---|---|---|---|
| Completeness | Can a reviewer find the source of every field, and the date it was entered? | Registered manager | No required field silently inferred. |
| Ownership | At each handoff, is the next responsible person visible without asking anyone? | Operations lead | Every held item carries a named owner. |
| The boundary | Where a professional decision is recorded, is it clear that a person made it? | Registered manager | No decision attributable to the system. |
| Recovery | What happens when the connection drops mid-visit, and when two people edit at once? | Supplier and delivery team | Offline working tested, no duplicate after a retry. |
| Cost at rest | What does the second year cost, including licences, training and turnover? | Finance | Renewal price agreed in writing before launch. |

Keep the first release narrow enough that every exception can be looked at individually.

# Questions for a first project.

These are the questions BespokeWorks would ask before proposing anything. They work as well against our work as against a supplier already in the building.

01 **Which tasks here are administrative, and which decisions must stay with an accountable professional?**

The answer draws the line the software must not cross. Written down early it is a design constraint. Discovered late it is a rebuild, and under Regulations 9 and 11 it is a regulatory problem as well.

02 **Who needs access to each type of information, and which existing system holds the authoritative record?**

Care information is special category data, and the condition most providers rely on carries a professional secrecy obligation that is frequently missed. Two systems each believing they are authoritative is the most expensive problem on this list.

03 **How should a changed schedule, a missing document or an unresolved task reach a responsible person?**

Most administrative failure in care is a handoff nobody owned. This question is worth more than any feature list, because it is the one a demonstration cannot answer for you.

04 **What would have to be true in two years for this to have been worth it, and who is measuring it?**

Nobody measured it for the national programme. A provider can still measure it for itself, and doing so is the only way to avoid repeating the exercise.

If a supplier cannot answer the first two without talking about their product, that is information as well.

Theo Coleman

Chief Technology Officer, BespokeWorks. September 2026

# Sources and scope.

Every figure is traced to the body that published it rather than to coverage of it, and nothing about artificial intelligence predates 2025. Claims were checked a second time by a pass whose only purpose was to refute them, which corrected four of them, including one that was simply wrong. Retrieved 16 September 2026.


Adult social care provider statistics, England: quarterly update to August 2026. Department of Health and Social Care, official statistics, 3 September 2026.

Findings from the 2025 adult social care provider technology survey. Department of Health and Social Care, official statistics, 6 March 2026. Voluntary survey, 1,085 responses, fieldwork February to March 2025.

Digital revolution in care saves millions of admin hours. Department of Health and Social Care press release, 5 December 2025.

Malley J, Westwood J, Snow M, Farrelly N, Steils N, Henderson C, Larkins C. A rapid evaluation of the implementation of Digital Social Care Records in England. Health and Social Care Delivery Research 14(16), May 2026.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936, Part 3. Regulations 9, 11, 12 and 17, with the commission's own guidance on Regulation 17.

Artificial intelligence in health and social care: CQC's role, expectations and plans. Care Quality Commission, page last updated 21 May 2026. Eleven principles.

Guidance on the use of AI-enabled ambient scribing products in health and care settings. NHS England, version 3, last updated 29 July 2026.

Innovation advice on artificial intelligence cameras in care home bedrooms. Information Commissioner's Office, undated, within a page last updated 16 December 2025.

Evaluation of test and learn of Magic Notes in Kent County Council. Health Innovation Kent Surrey Sussex with Unity Insights, 23 January 2026. A commissioned evaluation of a local authority assessment tool.

AI in adult social care. NHS England Digital case studies, last edited 10 June 2025. Every quantified figure on the page is reported by the provider or supplier.

A Minimum Price for Homecare April 2025 to March 2026. Homecare Association, December 2024. Headline rate £32.14 an hour.

Home care contract management. East Sussex County Council Audit Committee, 21 November 2025, on an audit completed in March 2025.

GP Connect Access Record, NHS England Digital, last edited 3 September 2026, and GP Connect: Update Record frequently asked questions, last updated 3 November 2025.

Proxy access to GP online services by care home staff. NHS England. The page carries no publication or last-updated date.

Health Bill: single patient record fact sheet, Department of Health and Social Care, 19 May 2026, with impact assessment DHSCIA9697, dated 6 January 2026.

Digital social care records: assured solutions and core capabilities. NHS England. Twenty-three solutions as listed on 16 September 2026; the page shows no date.


Photographs are illustrative and show no BespokeWorks client, member of staff or premises. Cover: photograph by Busranur Aydin on Pexels. Page 3: photograph by Pavel Danilyuk on Pexels.

## What could not be established

How much time care and care-office staff in England spend on administration has never been measured, and the claim that it runs to a third of their day traces to supplier material rather than to research. No figure exists for how many independent providers hold shared care record access. Two published compliance dates for the minimum operational data standard conflict, at 31 August 2025 and 1 July 2026. Where sources disagree this guide gives both rather than choosing. Several NHS England pages it relies on carry no date at all.