

ABIHI

APPS AND WEARABLES STRATEGY

EXECUTIVE SUMMARY

Evidence-based apps and wearables could play an important role in delivering the NHS's ambitions to move care from hospital to community, from analogue to digital and from sickness to prevention. These technologies can help people understand and manage their health between appointments, support earlier intervention and enable care beyond traditional settings.

The UK has significant strengths in digital health innovation, research and product development. However, innovation does not consistently translate into routine NHS use. Even where technologies have generated evidence and demonstrated value, the next step is not always clear. Different local requirements and repeated assessment can delay progress and make wider adoption difficult.

Many of these barriers affect innovation across HealthTech. However, apps and wearables experience particular challenges because they evolve rapidly, often rely on recurring expenditure and may require changes to pathways, workflows and clinical responsibilities. They can also operate across organisational boundaries, making it difficult to identify the appropriate commissioner and budget holder.

The NHS should take practical action now to expand access to technologies that are ready for use, while pursuing the longer-term reforms needed to make adoption more consistent and sustainable. HealthStore, the National HealthTech Access Pathway, MedTech Compass and the Innovator Passport provide important foundations, but their value will depend on how effectively they connect evaluation, funding and implementation.



THE STRATEGY MAKES FOUR PRIMARY RECOMMENDATIONS



Create a coordinated route from recognised need to an adoption decision

Evaluation should begin with a clearly defined need, evidence gap and intended decision. Pilots should address specific questions, with agreed outcomes, success criteria and progression points. Findings should be shared so that NHS organisations can build on previous learning rather than repeatedly addressing the same questions.



Establish predictable routes to reimbursement and routine commissioning

Technologies that demonstrate value need a clear route to sustainable funding. Eligibility, commissioning responsibility, budget ownership and implementation funding should be defined. The NHS should deliver its commitment to central procurement through HealthStore while testing regional models where commissioning closer to the population or pathway is more appropriate.



Coordinate regulatory, evidence and NHS assurance requirements

Regulation, value assessment and NHS assurance serve different purposes, but evidence should build across the product lifecycle. Requirements should be clear and proportionate, with evidence reused where appropriate. ABHI will develop its detailed regulatory proposals further with members, the MHRA and relevant partners before adopting them as formal policy positions.



Build structured implementation capability and continuous learning

Successful adoption requires more than purchasing a product. NHS organisations need defined ownership, appropriate expertise, workforce capacity and continued support. Technology readiness should be assessed alongside service readiness, with learning shared from successful, unsuccessful and discontinued deployments.

Delivery

ABHI's role will vary according to the action required. We will lead where activity falls within our remit, convene relevant partners where ownership is unclear and represent industry within programmes already under way. Where another organisation is better placed to deliver, ABHI will support a clear handover while continuing to monitor progress.

Progress will be measured through indicators including the time from evaluation to funding decisions, reuse of evidence and assurance, reduction in repeated pilots, availability of sustainable commissioning, uptake beyond initial sites, patient access and equity, and industry confidence in navigating NHS routes.

The ultimate measure of success will be whether more patients can access effective technologies, NHS organisations can implement them sustainably and companies face a clearer and more predictable route into routine NHS use.

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PART 1: VISION AND CASE FOR ACTION

VISION STATEMENT

ABHI's vision is for evidence-based apps and wearables to become trusted and routinely used components of the NHS care ecosystem. This reflects the shared ambition of the NHS and industry to use technology to support the shifts from hospital to community, analogue to digital and sickness to prevention set out in the NHS 10-Year Health Plan.

These technologies are already helping people manage their health, supporting earlier intervention and enabling care beyond traditional settings. Used at greater scale, they could improve access, mitigate and prevent deterioration and help the NHS make better use of its workforce and resources.

The immediate priority is to bring these benefits to more patients. Progress should not wait for every structural barrier to be resolved or for an entirely new system to be created. The NHS should build on existing clinical pathways, commissioning arrangements and digital infrastructure to scale technologies that already have sufficient evidence, regulatory clarity, demonstrated performance and service readiness, giving clinicians and patients confidence that the information generated is reliable, clinically meaningful and capable of supporting action. This requires dedicated funding, clear national and local ownership, and support for implementation at meaningful scale rather than cycles of isolated pilots.

In parallel, the UK needs a clearer and more sustainable route from identified need to routine adoption. Too many technologies remain outside NHS care because funding is short term, responsibility for adoption is unclear, and successful implementation does not reliably lead to wider uptake. Technologies should be introduced as part of clinical and service pathways, with funding and capacity for patient identification, workforce training, integration and ongoing support. Outcomes should be monitored from the outset to determine whether technologies should be scaled, improved or stopped, and adoption must reflect different patient needs so that digital care does not widen inequalities in access, participation or benefit.

Through this strategy, ABHI will work with partners to pursue immediate delivery and longer-term reform together. We will support action to scale technologies that are ready now, using existing infrastructure wherever possible, while addressing wider barriers across regulation, evidence, funding, commissioning, implementation and reimbursement. The aim is to establish a practical and repeatable route through which successful adoption leads to sustainable NHS use. A more predictable and commercially viable market would help the UK retain innovative companies, attract investment and become a leading European destination for building and scaling digital health businesses. This would turn existing innovation and investment into meaningful benefit for patients, the NHS and the UK economy.

WHY NOW?

The NHS is under sustained pressure. In June 2026 the elective waiting list in England stood at around 7.27 million cases, involving approximately 6.15 million individual patients, with about 106,000 people waiting more than a year to start treatment. The median wait was 11.9 weeks, compared with 7.5 weeks in June 2019 ([BMA analysis of NHS England referral to treatment data](#)). Demand is rising as the population ages and more people live with multiple long-term conditions, while services continue to face workforce constraints. Without changes to how care is delivered, these pressures will become increasingly difficult to manage.

The [NHS 10-Year Health Plan](#) therefore sets a clear direction for reform through three shifts. Apps and wearables can help turn these ambitions into practical changes in care, with wearable technologies being referenced as one of the '5 Big Bets' within the plan. They can support earlier identification of risk, provide timely interventions, and enable people to manage their health outside traditional clinical settings. Wearables can help clinical teams maintain oversight between appointments, where the data generated is relevant, reliable and connected to a clear course of action.

The opportunity is not simply to digitise existing services. Used as part of pathway redesign, these technologies can help shift appropriate care into community and home settings. They can give people greater control over their health and help clinical teams target support where it is most needed. However, placing technology on top of existing pathways without changing roles, workflows or clinical capacity can add work rather than release it. Technology adoption must therefore be considered alongside the readiness of the service expected to use it.

SUPPORTING A MORE PREVENTATIVE AND NEIGHBOURHOOD-BASED NHS

The move towards prevention and neighbourhood health creates a particularly important role for apps and wearables, as outlined in the 10-Year Health Plan. These technologies can support people before they reach crisis or require hospital treatment. They can help identify changes in health earlier and provide support between interactions with health services. They may also strengthen continuity across primary, community and specialist care.

Apps and wearables can provide a fuller picture of symptoms and changes in health between appointments, helping individuals and care teams identify meaningful trends earlier and support more timely interventions where appropriate.

Their value depends on addressing a recognised need, generating clinically meaningful information and connecting to a pathway able to respond. The strategy therefore considers both their potential and the conditions required to realise it.

The accessibility of digital care will also determine whether it reduces or widens health inequalities. Digital technologies can widen access by helping people receive support in ways that fit around work, caring responsibilities or access to clinical settings. However, they can create new barriers where people lack suitable devices, connectivity or confidence. Survey data indicates that while around 30% of UK adults use a smartwatch and 18% a fitness tracker, 54% use no wearable device at all, rising to 66% of those aged 55 and over ([YouGov Surveys, March 2025](#)). Digital care must therefore be designed around different population needs, with appropriate support and non-digital alternatives available where required.

RESPONDING TO THE CONSUMERISATION OF HEALTH

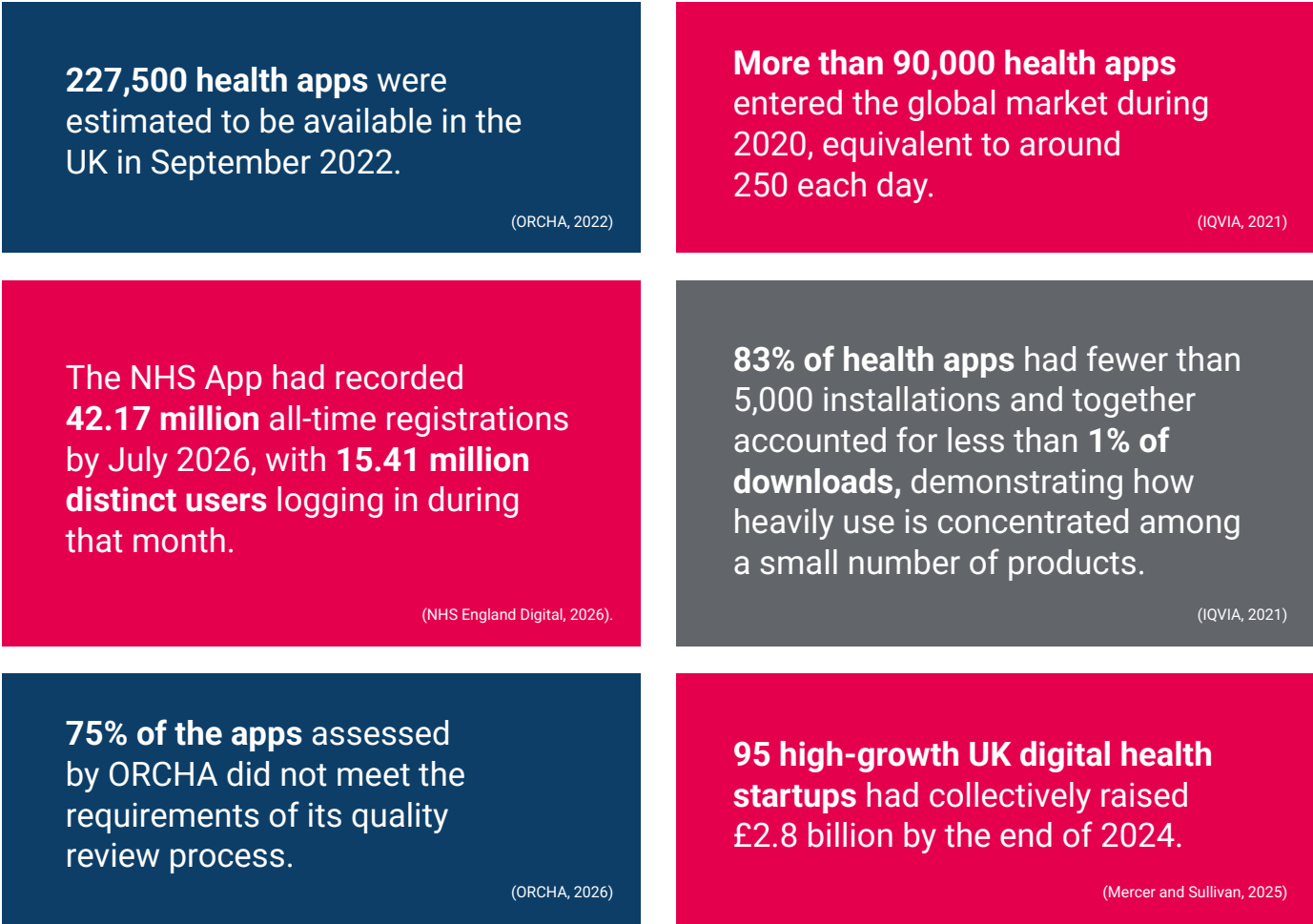
People are increasingly using apps and wearables to monitor activity, sleep and physiological measures, often independently of the NHS. A 2024 YouGov survey found that 67% of UK adults had used an app or device to track at least one aspect of their health, including exercise, weight or diet, heart rate, sleep and blood pressure ([YouGov, 2024](#)). More recently, a 2026 survey of 2,000 UK adults found that 57% used technology that monitors health indicators, while 35% had referred to wearable data when speaking to a healthcare professional. Yet many users lacked confidence in interpreting the information, reinforcing the need for clearer guidance for both the public and clinicians ([Cromwell Hospital, 2026](#)).

These trends mean that information and alerts generated outside formal NHS pathways are increasingly entering clinical conversations. As patient-generated health information becomes increasingly common, the NHS will need greater clarity on how clinically relevant data can be interpreted and incorporated into care pathways in a consistent and evidence-based way and a mechanism for preparing staff and pathways to respond, ensuring that access does not depend solely on an individual's ability to purchase technology.



THE UK DIGITAL HEALTH SECTOR: AT A GLANCE

There is no single, current dataset capturing the full range of apps and wearables available in the UK. Available market data use different definitions and some estimates are now several years old. The figures should therefore be treated as an indicative snapshot of the sector, rather than a definitive assessment of the current UK market.



The market is large, but availability, quality, uptake and sustained use are different measures. A clearer route is needed to help evidence-based technologies become visible, trusted and routinely adopted within NHS care.

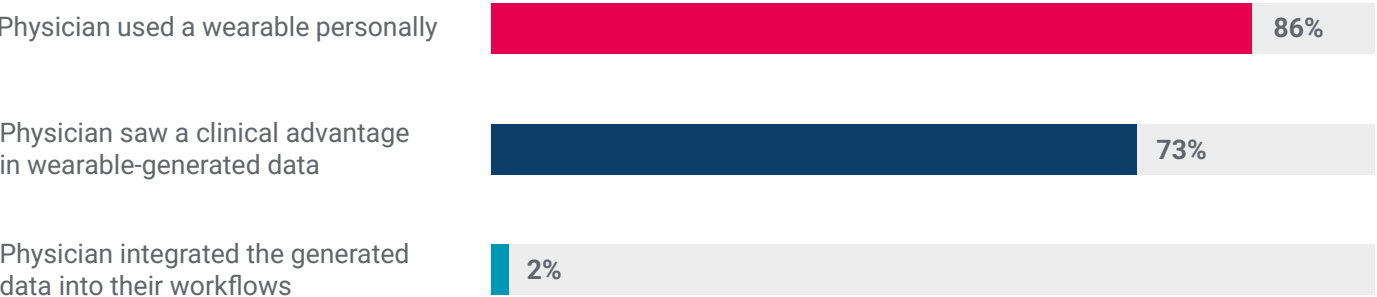
CONVERTING INNOVATION INTO ROUTINE CARE

The scale of the UK digital health sector does not consistently translate into NHS adoption. Industry participants described companies navigating regulation, generating evidence and completing successful pilots, only to encounter uncertainty around funding and implementation. Requirements vary between NHS organisations, and evidence or assurance information accepted in one setting may be revisited elsewhere. Stakeholders reported that adoption can remain dependent on individual champions and short-term funding rather than a consistent pathway.

A recent international survey found that 86% of UK physician respondents used a wearable personally and 73% saw a clinical advantage in wearable-generated data, yet only 2% reported that such data were integrated into their workflows. Across the six countries surveyed, integration was associated with structural conditions including payment, workflow infrastructure, evidence confidence, interpretive skills and liability clarity (American Medical Association, July 2026). The findings suggest that clinical interest alone is insufficient without practical routes for using wearable data in care.

Technologies should progress where they demonstrate value and can be implemented safely. They should be improved where evidence or usability gaps can be addressed and stopped where they do not meet agreed requirements. This requires more disciplined evaluation and better sharing of what has been learned, including the examples where technologies were not adopted.

International physician survey on consumer wearables - UK respondent results



SUPPORTING UK GROWTH AND COMPETITIVENESS

The NHS's ability to adopt innovation is closely connected to the UK's wider economic ambitions.

In 2023/24, an estimated 6,170 businesses operated across 7,320 companies in the UK life sciences industry, employing 359,600 people and generating £146.9 billion in turnover. Medical technology accounted for 60% of companies and 55% of employment (OLS, 2025). Building on this strength, the [Life Sciences Sector Plan](#) aims to make the UK Europe's leading life sciences economy by 2030 and the third globally by 2035. It recognises that achieving this ambition will require a faster and better-coordinated route from discovery to delivery, supported by greater accountability and partnership with industry.

For apps and wearables, an attractive innovation environment depends on more than strengths in research and product development. Companies also need confidence that technologies meeting the required standards have a credible route into routine use. Persistent uncertainty around reimbursement and commissioning can discourage investment in NHS-focused products. It can also lead smaller companies to prioritise overseas markets where the commercial pathway is perceived to be clearer. This risks weakening the UK's ability to retain and attract digital health businesses, reducing investment in the economy and limiting NHS and patient access to innovation.

This strategy does not seek to define the UK's wider international regulatory policy. However, changes intended to accelerate domestic access should be developed with regard to international alignment and should avoid creating UK-specific requirements that unnecessarily limit export potential.

A more predictable adoption pathway would support both health and economic objectives. It would help patients access effective innovation more consistently, give the NHS greater confidence in adoption decisions and provide companies with a clearer basis for investment. In this way, **NHS reform and UK growth should be seen as connected goals.**



ALIGNING EXISTING NATIONAL AND REGIONAL INITIATIVES

This strategy is designed to work with the grain of existing policy rather than duplicate it.

The three shifts in the [NHS 10-Year Health Plan](#) provide the central policy context, and the [Life Sciences Sector Plan](#) reinforces the importance of accelerating access to innovation and creating a stronger environment in which companies can start, scale and invest. Where existing mechanisms can deliver against these ambitions, they should be strengthened, connected and used. Where they cannot, new arrangements should be explored, detailed throughout this strategy.

The emerging adoption landscape also includes mechanisms such as HealthStore, the National HealthTech Access Pathway (NHAP), the Innovator Passport and MedTech Compass.

These initiatives offer an opportunity to improve the route from evidence to adoption, but their development must be matched by ambition in both scale and pace of delivery. Their success will depend on sufficient resourcing, the ability to assess and onboard technologies efficiently, and a commitment to delivering meaningful improvements in how innovation reaches patients.

ABHI will work collaboratively with national partners to support the development and delivery of these initiatives, ensuring that industry experience helps shape how they operate in practice. At the same time, these longer-term reforms should not delay progress. ABHI will advocate for practical interim approaches that can be explored in parallel, particularly where they could provide more immediate routes to funding, commissioning and adoption.

THE COST OF INACTION

The cost of inaction is immediate. Patients could already be benefiting from evidence-based apps and wearables, yet too many remain outside routine NHS care. Without a sustainable route from evidence generation to adoption, the NHS risks failing to realise the return from public and private investment, while companies may prioritise markets offering greater commercial certainty.

The case for action is therefore not simply that apps and wearables offer future potential. These technologies are already influencing how people manage their health and interact with NHS services. The strategic choice is whether their role develops through continued fragmentation, or through a more coherent approach that supports safe adoption, sustainable implementation and more consistent benefit for patients.

01 Delayed and unequal patient access

Patients may continue to wait for effective technologies to become available through routine NHS pathways, even where evidence and clinical demand already exists. Access will remain dependent on geography, local capacity or the presence of individual champions, contributing to variation between services and regions.

02 Continued duplication of pilots and evaluation

NHS organisations and companies will continue to invest in local pilots without a clear decision about what should happen next. Evidence generated in one setting may remain difficult to transfer elsewhere, while unsuccessful or inconclusive findings may not be shared. This creates repeated cost without building a reliable national evidence base.

03 Unrealised value from NHS and industry investment

Evidence generation, assurance and implementation require significant time and resources. Where there is no sustainable route beyond a successful evaluation, that investment may not translate into improved care. NHS teams may spend scarce capacity repeating checks, while companies face growing costs without a predictable commercial outcome.

04 Loss of innovative companies and investment

Poorly defined routes to reimbursement and scale make NHS-focused business models less attractive to investors. Venture capital may be withheld or provided on the expectation that companies will pursue growth in overseas markets with clearer commercial pathways. SMEs may also lack the resources to remain in the NHS market while navigating repeated local processes. This risks the UK investing in the development and evaluation of innovation without retaining the companies or realising the benefits for NHS patients and the wider economy.

05 Greater reliance on poorly evidenced consumer products

Where evidence-based technologies are not available through NHS pathways, people may instead turn to readily available consumer products whose evidence and clinical value vary. This can create inconsistent support and increase uncertainty for patients and clinicians.

06 Widening inequalities

Fragmented adoption is likely to benefit organisations and populations with the strongest digital infrastructure and implementation capacity. People without suitable devices, connectivity or digital confidence may be less able to access new forms of care. Without deliberate action, digital transformation could reinforce existing regional and socioeconomic inequalities rather than reduce them.

PART 2: PRIORITY USE CASES

MENTAL HEALTH

Mental health is a strong use case for demonstrating the potential of apps and wearables.

Services face high demand, long waits and constrained clinical capacity, while a relatively mature market of digital interventions already exists. NHS Talking Therapies alone received 1.81 million referrals in 2024–25, of which 1.21 million went on to access services ([NHS England Digital, NHS Talking Therapies annual report, 2024-25](#)). These technologies can support people at different points in their journey, from prevention and early support through to assessment, treatment and ongoing management.

Digital tools could help people access support earlier, including while they wait for formal care. Regulated digital therapeutics can deliver structured interventions for defined conditions, independently or alongside clinical support. Digital assessment tools may also streamline parts of mental health pathways by standardising information gathering and making better use of clinical time.

Wearables present a less mature but potentially important opportunity. Research is exploring whether changes in sleep, physical activity and physiological measures could indicate deterioration or relapse, particularly among people with severe mental illness. A systematic review of consumer-grade wearables in severe mental illness found some evidence that lower activity, higher heart rate and later or irregular sleep onset were associated with poorer symptoms or mental health status, although differences in devices, measures and methods limited interpretation ([Hassan et al., 2025](#)). A broader review across psychiatric conditions found that passively

collected smartphone and wearable data showed potential for predicting relapse or clinical deterioration, although high risk of bias and reliance on internal validation limited confidence in real-world performance ([Fang and Chen, 2026](#)).

Digital mental health also presents distinctive implementation challenges. Engagement and adherence can be difficult to sustain, with individual, technology and programme-level factors all influencing use ([Yap et al., 2026](#); [Lipschitz et al., 2023](#)). Stakeholders also raised concerns that fragmented pathways may require people to navigate multiple apps and platforms. Evidence from CAMHS suggests that clinician attitudes, knowledge and confidence can influence whether digital technologies are adopted ([Cliffe et al., 2020](#)). Decisions about digital support should therefore be informed by lived experience, recognising that preferences vary and people should have meaningful choices about the role of technology in their care ([The Wellcome Trust, 2024](#)). Furthermore, digital interventions should provide a simple experience and complement, rather than replace, appropriate human support, particularly for people who may experience cognitive, motivational or access barriers ([Jerjes et al., 2025](#)).

Clinical escalation is particularly important. Patients should understand how their data will be used, whether information is actively monitored and what response they can expect. Services should define who reviews indicators of deterioration, which outputs require action and how people access more intensive or urgent support. Digital technologies that identify risk should only be used where appropriate risk-management, governance and escalation arrangements are in place ([Hopkin et al., 2024](#); [NHS England, 2025](#)).

Mental health technologies should support whole-person care, recognising the close relationship between mental and physical health. People living with severe mental illness experience substantial physical health inequalities, including higher rates of preventable illness and significantly shorter life expectancy ([Jerjes et al., 2025](#); [NHS England, 2025](#)). Digital support should therefore reflect the person's wider health and circumstances rather than focus narrowly on a single condition. Where appropriate, information generated through these technologies could support more coordinated care across mental and physical health services.

Evidence and outcomes should reflect the characteristics of mental health care. Alongside clinical effectiveness, evaluation should consider access, patient experience, appropriate engagement and whether benefits are sustained. NICE's reformed HealthTech programme is a positive step, moving from a requirement for technologies to be cost saving towards assessment based on cost-effectiveness and patient benefit ([NICE, 2025](#)). Outcomes should extend beyond symptom improvement to include functioning, quality of life, wellbeing and personal recovery ([Correll et al., 2025](#)). Wider social and economic effects, including employment, may also be relevant where benefits extend beyond the organisation funding the intervention ([ONS, 2026](#)). Engagement should be assessed in relation to intended use and outcomes, rather than downloads, logins or frequency of use alone ([Yap et al., 2026](#)), a point also reinforced through stakeholder engagement.

Sustainable commissioning is equally important. Stakeholders reported that short-term funding can interrupt access after patients have begun using an intervention and weaken staff confidence after services have invested in implementation. Mental health therefore demonstrates the need for a joined-up model in which digital technologies support appropriate access, complement clinician-led care and remain available where ongoing evidence supports their use. Success should be judged through outcomes that matter to people, alongside clinical effectiveness and value for the health system.

WOMEN'S HEALTH

Women's health provides an important use case for apps and wearables. Evidence and lived experience highlight delays and inconsistencies in the recognition and support of some women's health needs (DHSC, 2022).

Digital technologies could help people record and understand symptoms over time, generating information that may support conversations with healthcare professionals. They may also contribute to more personalised care and inclusive women's health research (Grace et al., 2025).

Apps can support symptom tracking and help identify patterns linked to menstrual health, reproductive health and long-term conditions such as endometriosis. Wearable technologies can add continuous information on changes in sleep, activity or physiology. Stakeholders also highlighted emerging wearable therapeutics designed to deliver interventions at home, including neurostimulation for menstrual pain and related symptoms. These products challenge the assumption that wearables are used only for measurement, as some combine monitoring with an active therapeutic intervention.

Women's health also requires greater recognition of how common conditions affect women differently. Cardiovascular disease, for example, can present differently in women, yet women have historically been underrepresented in the research informing clinical guidance (Bastian-Pétré et al., 2024). Greater recognition of sex-specific risk factors and thresholds is therefore needed to support earlier identification and more personalised prevention (Appelman et al., 2026). Apps and wearables could contribute to this by supporting

ongoing monitoring and generating longitudinal health information, but their measurements and algorithms must be validated in the populations for whom they are intended.

Digital tools can also help people record and communicate symptoms that fluctuate over time or may be difficult to capture during a single appointment. However, collecting more information will improve care only where clinicians can interpret it and pathways can respond appropriately. Technology should support recognition and access to care, without placing greater responsibility on patients to demonstrate that their symptoms warrant attention.

Access is also shaped by affordability. Stakeholder engagement highlighted examples of evidence-based women's health technologies available directly to consumers but priced beyond the reach of many people. Where these products are not commissioned by the NHS, access can depend on an individual's ability to pay, potentially widening inequalities despite clear patient demand.

This reinforces the need for assessment and commissioning to recognise the wider value of women's health technologies. Effective support for conditions such as endometriosis and menstrual pain may improve symptoms and reduce healthcare use, while also supporting mental wellbeing, participation in daily life and the ability to remain in work. These wider outcomes should inform value assessment and commissioning decisions, alongside representative evidence and clear clinical pathways. This would help ensure that effective technologies are available according to need rather than ability to pay.

LONG-TERM CONDITION MANAGEMENT

Much of a person's health is managed between appointments, yet long-term condition pathways often rely on reviews at fixed intervals. Apps and wearables can provide greater visibility of changing needs, particularly where symptoms fluctuate or deterioration is unpredictable.

Cardiovascular health illustrates this opportunity: heart rate is among the measures most commonly tracked through wearable technology, while some devices include regulated features such as irregular rhythm notifications (Cromwell Hospital, 2026; UK Parliament POST, 2025).

Remote monitoring can provide information between appointments and may support earlier identification of changes in health and management at home, although effectiveness varies by condition, technology and model of implementation (de Bell et al., 2023). In cardiovascular care, wearables may support ongoing monitoring, risk assessment and intervention tracking, although their clinical value depends on valid measurements, appropriate interpretation and integration into a pathway able to respond (Jamieson et al., 2025).

Digital technologies can also provide tailored education, guidance and reminders and, in some cases, deliver therapeutic interventions. Used effectively, they can strengthen day-to-day self-management and provide clinical teams with information to support more timely and personalised care (NHS England; de Bell et al., 2023).

Long-term condition management should reflect the whole person, including the effect of a condition on emotional wellbeing, independence and participation in everyday life (Woodward et al., 2023). Digital support can help some people understand how their behaviours affect their health and build the knowledge, skills and confidence needed for self-management, although outcomes depend on the design of the intervention and the support available (Christie et al., 2024; NHS England, n.d.). Wider outcomes, including the ability to remain in work, may also be relevant when assessing value (NHS England, n.d.).

The wider value of long-term condition support can be difficult to demonstrate where outcomes and funding are assessed within individual pathways. Benefits may take several years to emerge or be realised elsewhere in the system, meaning that short evaluations and contracts may not capture sustained outcomes or the full return for patients, the NHS and wider society. Funding models should therefore support implementation and evaluation over an appropriate period and recognise value across services and beyond healthcare.

PART 3

THE CURRENT LANDSCAPE

The UK has established mechanisms for developing, regulating and evaluating health technologies, with the applicable route determined by a product's intended purpose, regulatory status and proposed role in care.

Regulated medical devices and IVDs operate within established regulatory and evidence frameworks, while consumer and wellness products may sit outside them. Different organisations assess different aspects of a technology for different purposes, but these processes do not yet form a consistently connected route into appropriate NHS use.

The greatest uncertainty arises once evidence has been generated. A positive evaluation does not consistently establish who should commission the technology, which budget should fund it or how implementation and ongoing delivery will be supported. Companies may need to repeat business cases and navigate different local requirements, while NHS organisations must assess affordability, pathway fit and service readiness without a standard route to follow. Technologies that have demonstrated value can therefore remain dependent on short-term funding, local capacity and individual champions rather than progressing predictably into routine care.

Many of these barriers, including fragmented decision-making, short-term funding and limited implementation capacity, affect innovation across HealthTech. However, apps and wearables experience particular challenges because they evolve rapidly, often depend on recurring expenditure and require changes to pathways, workflows and clinical responsibilities. They may also operate across organisational and clinical boundaries, making ownership and funding particularly difficult to establish. Emerging mechanisms such as HealthStore and the Innovator Passport provide opportunities to address some of these challenges, provided they connect effectively with existing regulatory, evidence, commissioning and implementation arrangements.

This section describes how the current landscape operates and where it breaks down. It draws on stakeholder interviews and workshops conducted during the strategy's development and reflects the experiences of industry and wider system partners. The recommendations that follow respond to the issues identified.

IDENTIFYING NEED AND DEVELOPING PRODUCTS

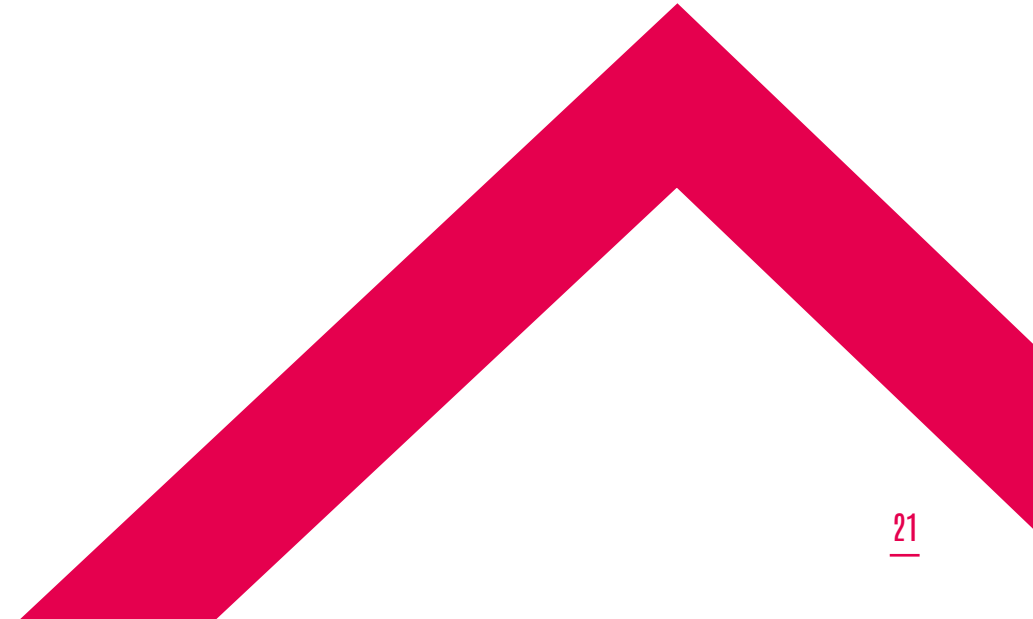
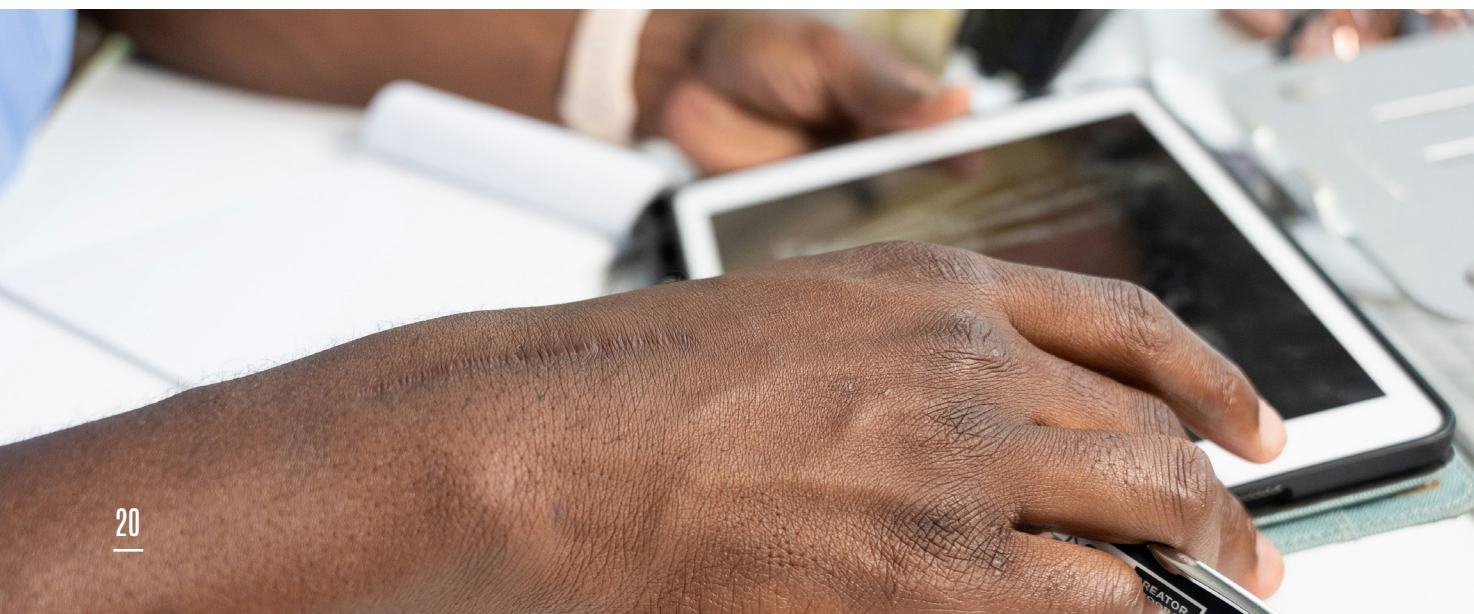
Innovation can be rooted in a strong understanding of patient or clinical need, including technologies developed by clinicians and people with direct experience of care. The UK also has an established ecosystem of public funding, academic networks, clinical research infrastructure and private investment supporting product development.

Recent collaboration between NICE and NIHR is a positive development. The April 2026 NIHR i4i Product Development Awards include a funding stream to support real-world evidence generation for technologies recommended through NICE early use assessment (NIHR, 2026). However, although welcomed, individual funding programmes cannot be a substitute for a standardised and sustainable route from evidence generation to routine commissioning.

That route must also be able to consider technologies that could change how care is delivered, rather than assessing them solely within existing pathways. Stakeholders raised concerns that emerging technologies may be overlooked where their value depends on pathway redesign, a new model of care or the replacement of existing activities. Evaluation should therefore consider both performance within current practice and the future pathway the technology could enable.

Technologies should not depend on securing one-off funding to generate evidence or bridge the gap into NHS use. A standardised route should provide earlier clarity on where a technology fits within care, who would commission it, how cost-effectiveness should be demonstrated and what evidence is required for adoption. It should also provide a visible route for technologies outside of prominent national priorities, where they address recognised unmet need.

Commissioners, finance teams and those responsible for implementation are often engaged only after a product has been developed or an evaluation is being planned. This can mean that evidence generation does not address the questions that will ultimately determine whether the technology can be funded, implemented and sustained. It also creates a disconnect between early investment and later adoption: the UK may support technologies through development and evaluation without providing a viable route into routine use, leading companies to consider markets with greater commercial certainty. There is currently no consistent point at which the feasibility of adoption is tested before significant investment is made.



REGULATION

Manufacturers are responsible for defining a product’s intended purpose, determining whether it is a medical device and meeting the relevant regulatory requirements. The MHRA sets the regulatory framework and oversees compliance for medical devices placed on the UK market.

Regulation provides important safeguards by requiring manufacturers to define a product’s intended purpose, demonstrate appropriate safety and performance, manage risks and monitor products once they enter the market. It also supports confidence among patients, clinicians and NHS decision-makers by providing greater transparency about the claims a product is permitted to make.

The market is currently segmented, with formal requirements applying to regulated medical technologies and wellness products sitting outside that framework. This leaves some lower-risk technologies without a proportionate route, while patients selecting products for themselves have little basis on which to judge whether a claim is supported. Clinicians are increasingly presented with data from devices the NHS has not procured and has no established way to interpret. Industry

stakeholders reported uncertainty about how intended purpose, product claims and influence on clinical care determine which regulatory requirements apply, and where the boundary sits for consumer wearables that combine wellness functions with regulated health features.

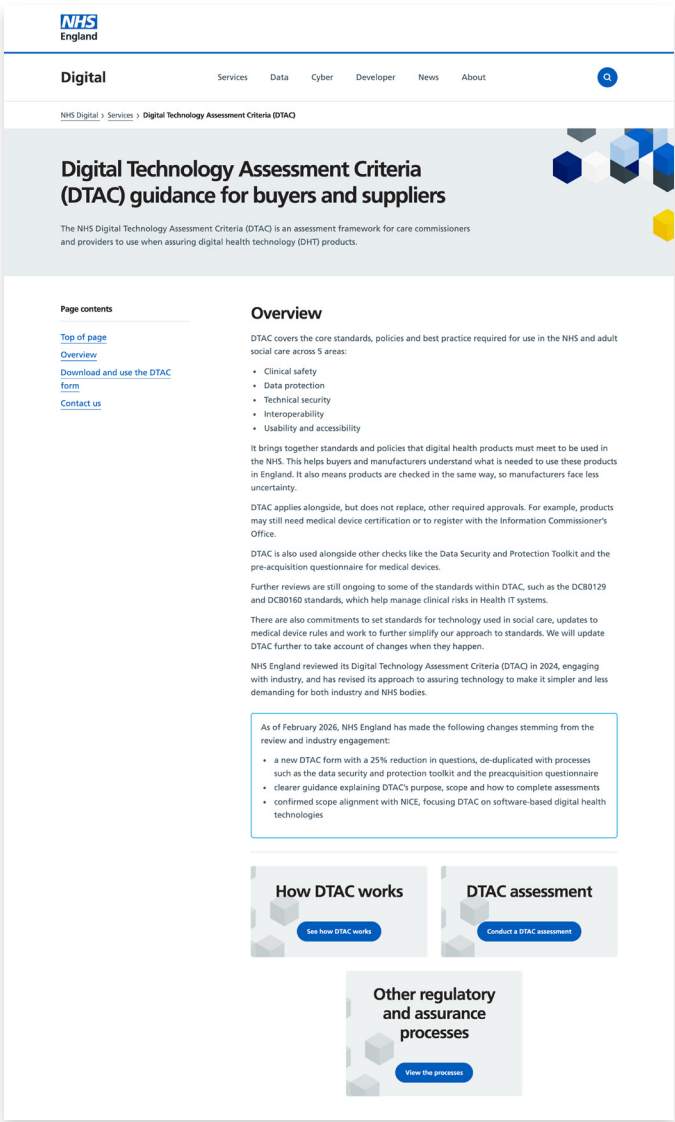
Pace is a further consideration here as software, algorithms and product functionality can change rapidly, and stakeholders reported that guidance can take time to reflect new capabilities and risks. They also described uncertainty about where the line falls between routine product updates and material changes affecting safety, performance or intended purpose, which can make it harder to plan incremental improvements to a product.

Regulatory approval confirms that a technology can legally be placed on the market for its intended purpose; it does not establish its value to the NHS or whether a service is ready to implement it. NICE evaluation can provide a national assessment of value, but local organisations may still require separate and varying business cases before committing funding.

NHS ASSURANCE

DTAC provides a national framework covering clinical safety, data protection, technical security, interoperability, usability and accessibility.

It is used by NHS organisations at the point of procurement to ensure that technologies meet baseline standards across these areas. In practice, suppliers are often asked to provide the same information in different formats across multiple organisations. Stakeholders described assurance and procurement processes taking many months rather than weeks, delaying deployment and placing additional pressure on local teams. For SMEs with limited funding runway, repeated assessments create significant cost and can threaten their ability to remain in the NHS market. The Innovator Passport is intended to address this. However, some industry stakeholders were concerned that, without a clear expectation of national acceptance, it could operate alongside existing local processes rather than replace them.



Source: NHS England website, accessed 16 October 2026. Contains public sector information licensed under the Open Government Licence v3.0.

EVIDENCE GENERATION AND EVALUATION

NICE's Evidence Standards Framework provides an important national basis for setting proportionate evidence expectations according to a technology's intended purpose, level of risk and role in care. However, stakeholders reported that the framework is not always applied consistently or clearly connected to the evidence required for commissioning, implementation and adoption.

For regulated technologies, evidence should develop across the product lifecycle rather than be generated separately for each decision. Evidence used to demonstrate safety and performance should provide a foundation for subsequent assessment of clinical and economic value, commissioning and post-market learning, while recognising that each process answers a different question.

Stakeholders indicated that evidence requirements are frequently set after evaluation has been designed and without input from the commissioners, finance teams and services that will ultimately decide whether the technology is used. As software, algorithms and hardware evolve, clearer guidance is needed on when changes require updated evidence or further evaluation. HRC participants highlighted the need for clearer and more consistent approaches to validating wearable

measurements, risk indicators and AI-generated alerts in the intended population, including agreed thresholds and guidance on the clinical response required. Transparency around measurement performance and validation is particularly important where wearable-derived information may inform clinical decisions, helping to support confidence among clinicians, commissioners and patients.

Crucially, generating the required evidence does not reliably lead to a decision. Industry consistently reported that successful evaluations, evidence of value and even NICE guidance and recommendations do not necessarily result in commissioning or funding. Companies may instead face repeated evidence requests across different NHS organisations, without clarity about when the evidence will be considered sufficient or what meeting the requirement will unlock. This imposes pressure on SMEs and weakens the incentive to invest in further NHS-focused evidence generation. The issue is not a shortage of frameworks, but limited coordination and reuse of evidence across the lifecycle. Each process should be clear about what has already been established, what additional evidence is needed and which decision that evidence will inform.

COMMISSIONING, PROCUREMENT AND FUNDING

Commissioning responsibility may sit with ICBs, NHS England for specialised services, or provider organisations, and the clinical team making the case for adoption may not hold the budget or the decision.

Procurement is a separate step, running through a trust's own processes, or a national framework. Each route brings its own requirements, evidence expectations and timescales. Technologies that operate across pathways, support prevention or address several conditions may have no clear commissioner at all, particularly where the service funding the intervention is not the one that benefits.

Companies may therefore need to engage multiple decision-makers, repeat business cases and navigate different local procurement requirements. Commissioner understanding of software-based medical technologies also varies, meaning adoption can depend on individual relationships and local champions rather than a consistent route for technologies that have demonstrated value. Stakeholders described prolonged procurement processes, repeated local requirements and teams struggling to navigate unfamiliar digital processes. For SMEs, this increases costs, defers revenue and limits their ability to scale within the NHS. Reliance on individual champions also makes adoption inconsistent and vulnerable to changes in staff capacity or personnel.

England also lacks a consistent reimbursement mechanism linking evidence of value to routine funding for digital technologies. Peer countries have introduced more defined routes: Germany's DiGA pathway enables eligible digital health applications to enter a national directory for reimbursement, while France's PECAN scheme provides time-limited early coverage as further evidence is generated (BfArM, 2026; G_NIUS, 2026). These schemes are limited to defined categories and do not remove all barriers to uptake, but they demonstrate the value of clearer eligibility criteria, evidence requirements and routes to funding (van Kessel et al., 2023).

Funding is instead drawn from existing service budgets, non-recurrent transformation programmes and short-term innovation funds. NHS organisations may also face a choice between investing in technology and protecting existing workforce capacity, with familiar staffing models perceived as less risky even where digital adoption could support longer-term transformation.

Short funding cycles compound this problem. They may not provide enough time to redesign pathways, build confidence or demonstrate sustained outcomes, particularly where preventative and wider benefits take several years to emerge or are realised elsewhere in the system. Non-recurrent funding also favours one-off capital investment over the ongoing expenditure needed for digital adoption, making it difficult for organisations to invest in new staffing models or commit to recurring costs such as software licences and implementation support. Without more sustainable funding routes, the NHS risks delaying adoption further and failing to unlock the benefits that evidence-based digital technologies could deliver for patients, the workforce and the wider system.

Emerging national initiatives could address parts of this gap, but their development must not delay action. Evidence-based apps and wearables can already help people understand and manage their health more proactively between appointments. ABHI will therefore work with government and the NHS to shape longer-term reform while supporting practical action through existing pathways, budgets and infrastructure. ICBs and providers should use population health approaches to identify suitable patients, commission technologies at meaningful scale and monitor outcomes through routinely collected data. Multi-year contracts, regional collaboration and greater reuse of evidence could support adoption now, without creating new dependencies or waiting for an entirely new funding mechanism.

IMPLEMENTATION, SCALE AND ONGOING LEARNING

Implementation is primarily led within the adopting NHS organisation, with clinical, operational and digital teams working alongside the supplier. However, feedback indicates that implementation requirements are often considered after procurement or once deployment planning has begun.

Organisations may lack the infrastructure, workforce capacity or change-management support needed to embed a technology effectively. When implementation is treated as software deployment rather than service transformation, technologies can add workload or fail to deliver their intended value.

Successful adoption often depends on local champions who understand the technology, build support and navigate organisational processes. These individuals can be critical, but their role is neither standardised nor consistently resourced. It often sits alongside existing responsibilities, making implementation dependent on individual capacity and vulnerable to staff changes. One international example described US hospitals where clinicians qualified in digital health had the knowledge and authority to guide a product from commissioning and procurement through to implementation

and adoption. While not directly transferable, it illustrates the value of recognised digital adoption roles combining clinical understanding with technical and commercial expertise.

Post-launch support is indicative of successful implementation. Stakeholders shared examples of structured implementation continuing beyond launch through formal plans, cross-functional governance and regular follow-up. These approaches supported monitoring, workforce engagement and the resolution of implementation barriers. However, the engagement also highlighted variation in the support available across NHS organisations and continued reliance on individual champions.

Furthermore, findings from pilots and local evaluations are rarely validated or shared in a way that others can build on, and the reasons a deployment succeeded or failed are infrequently captured and widely disseminated as learnings. As a result, organisations repeat evaluations that have already been carried out elsewhere, industry receives limited structured feedback, and there is no reliable basis for deciding whether technologies should be sustained, adapted or withdrawn.

PART 4

RECOMMENDATIONS

Creating a reliable route into routine NHS use requires action across four connected areas.

The recommendations cover the journey from identifying need and evaluating technologies through to funding, implementation and sustained use.

Recommendation 1	Focuses on reaching a clear adoption decision.
Recommendation 2	Addresses commissioning and sustainable funding.
Recommendation 3	Clarifies the regulatory, evidence and assurance requirements that support those decisions.
Recommendation 4	Focuses on implementation, sustained use and learning.

RECOMMENDATION 1

CREATE A COORDINATED ROUTE FROM UNMET NEED TO ROUTINE ADOPTION

Primary recommendation

Establish a nationally coordinated route from recognised NHS need to routine adoption, connecting the relevant evaluation, commissioning and access mechanisms.

The route should recognise that technologies may follow different pathways according to their intended use, evidence maturity and regulatory status. It should clarify which mechanisms apply, how they connect and what demonstrating value will unlock. Successful evaluation should lead to a timely and transparent commissioning decision, rather than repeated assessment or uncertainty about the next step.

Building on: NHAP, MedTech Compass, NICE evaluations and support via the HINs and HRCs.

Gap: Unclear connections, lack of standardisation, fragmentation in commissioning and procurement processes, repeated pilots and no consistent outcomes.

Likely owners: DHSC, NHSE, NICE, ICBs, HINs, HRCs

ABHI role: Influence, convene, represent industry

1.1 Introduce an early feasibility checkpoint

Assess need, pathway fit and adoption feasibility before significant investment in evaluation. This should identify the relevant route, decision-maker and evidence gap, without creating another approval gateway.

1.2 Provide clearer signals of NHS demand

NHS England should publish regularly updated priorities, including the needs being addressed and likely routes to evaluation and adoption. Technologies outside national priority areas should retain a visible route to consideration.

1.3 Replace open-ended pilots with purposeful evaluation

Use pilots only to address a defined evidence or implementation gap. National evaluation bodies, HRCs, Health Innovation Networks, NHS organisations and industry should jointly develop a best-practice guide covering outcomes, success criteria, decision-making responsibilities and the route beyond evaluation.

1.4 Share evaluation and implementation learning

Bring together validated findings from successful, inconclusive and discontinued evaluations, building on MedTech Compass and existing infrastructure. The resource should capture outcomes, implementation requirements and reasons for adaptation or non-adoption.

1.5 Establish clear progression points

Every evaluation should lead to a transparent decision and defined next step. Companies should understand who makes the decision, what has been established and whether further development or evaluation is required.

1.6 Involve patients and the public throughout

Patients and carers should help define the need, priority outcomes and acceptable use. The organisation leading the relevant stage should resource their involvement and ensure participation reflects the intended population, including people least likely to be digitally connected.

RECOMMENDATION 2

ESTABLISH A PREDICTABLE ROUTE TO REIMBURSEMENT & ROUTINE COMMISSIONING

Primary recommendation

Create nationally recognised routes through which technologies that demonstrate value can secure sustainable NHS funding and routine commissioning.

These routes should clarify eligibility, the appropriate commissioning level, budget ownership and how implementation and ongoing delivery will be funded.

Building on: HealthStore and NHAP's central funding commitments, regional commissioning approaches and existing purchasing routes.

Gap: No consistent route for technologies to secure central or sustainable funding, no established mechanism linking product value to recurrent funding.

Likely owners: DHSC, NHSE, NICE, ICBs, MHRA

ABHI role: Support model development, convene, represent industry, advocate

2.1 Set clear funding routes and responsibilities

Define which technologies qualify, the requirements they must meet and how funding decisions will be made. Successful NICE evaluations should trigger a timely and transparent decision. Commissioning responsibility should be clear for technologies operating within and across pathways.

2.2 Deliver central and test regional reimbursement models

Deliver the 10-Year Health Plan commitment to procure NICE-evaluated technologies once for the NHS, with costs met from central budgets through HealthStore. Alongside this, test regionally coordinated reimbursement models for technologies outside its initial scope, including outcome-linked funding and prescribing approaches.

2.3 Support adoption while national routes develop

While HealthStore and other national routes develop, support regional commissioning through existing budgets and infrastructure, with funding linked to agreed outcomes and real-world evidence. This should enable earlier access without weakening the commitment to central procurement.

2.4 Recognise cross-system and longer-term value

Funding decisions should recognise benefits realised across services and over longer periods, including prevention, earlier intervention, quality of life, independence, workforce productivity and participation in work.

2.5 Fund implementation, not just the product

Funding should cover integration, pathway redesign, workforce preparation, patient onboarding and ongoing support, not only the technology itself.

2.6 Use longer-term contracts

Use commissioning periods that allow technologies to embed and demonstrate sustained value, with proportionate review points based on real-world performance.

RECOMMENDATION 3

STRENGTHEN AND CONNECT REGULATORY, EVIDENCE AND ASSURANCE ROUTES

Primary recommendation

Improve clarity and coordination across regulation, evidence generation and NHS assurance. Each process should have a defined purpose; recognise information already assessed and specify what additional evidence is needed for the decision it supports.

Regulatory authorisation, value assessment and commissioning serve different purposes, but evidence should build across the product lifecycle. The MHRA, NICE, NHS England and commissioners should clarify how evidence generated for safety and performance can inform subsequent assessment and where additional evidence is required.

Building on: MHRA guidance, NICE ESF, DTAC, NICE evaluations, NIHR i4i funding and the Innovator Passport.

Gap: Inconsistent interpretation, limited portability and unclear sequencing and repeated local assurance.

Likely owners: MHRA, NICE, NHS England, DHSC and NIHR

ABHI role: Provide industry evidence, convene policy development and shape practical implementation.

ABHI will validate more detailed proposals as part of the strategy implementation, with members, the MHRA and relevant external stakeholders before adopting them as formal policy positions.

3.1 Clarify product classification

Work with the MHRA and industry to assess how borderline guidance could be introduced to navigate the space between wellness and regulated device and kept current, including through additional worked examples or a more regularly updated digital resource. This would help innovators identify the correct route earlier and enable patients and NHS decision-makers to understand each product's intended purpose, regulatory status and limitations.

3.2 Create proportionate and adaptive regulatory routes

Explore with the MHRA whether more proportionate regulatory routes are needed for genuinely low-risk technologies that do not fit comfortably within current wellness or medical-device categories. Requirements should increase in line with a product's intended purpose, claims, clinical influence and potential for harm, while retaining appropriate evidence, transparency and post-market monitoring.

This work should take account of the National Commission into the Regulation of AI in Healthcare's support for proportionate, lifecycle-based regulation and proposed Health Bill reforms intended to create a more responsive regulatory framework. It should explore greater flexibility in how requirements are applied and updated across product categories, alongside international alignment, recognition and reliance. ABHI will develop and test its detailed position with members, the MHRA and relevant partners before adopting formal policy proposals.

3.3 Map out and summarise evidence frameworks across the landscape

Map existing regulatory, evidence, evaluation and post-market requirements to show how evidence should build across the product lifecycle. This should clarify what is needed at each stage, where evidence can be reused and which decision each requirement supports.

3.4 Strengthen the use of real-world evidence

Agree proportionate real-world evidence plans setting out outcomes, responsibilities and review points. Findings should inform value assessment, commissioning, product development and, where relevant, regulatory monitoring, with a defined route into business-as-usual commissioning addressed under Recommendation 2.

3.5 Validate AI-enabled technologies in representative NHS populations

AI-enabled apps and wearables should demonstrate performance in populations representative of their intended NHS use, including across relevant patient groups. Monitoring should continue after deployment to identify changes in performance as models or data change. AI regulatory sandboxes could support this by enabling controlled testing in representative NHS settings, with agreed requirements for subgroup performance and ongoing monitoring.

3.6 Standardise and integrate wearable data

Develop consistent expectations for developers around the publication of wearable measurements, including derivation, validation, intended populations, limitations, interpretation and the clinical or behavioural actions that the information is intended to support.

Further work should determine where national measurement or digital biomarker standards are required. The NHS should also define how clinically relevant wearable data can be recorded and shared with its systems in a usable form, with proportionate integration requirements agreed before procurement.

3.7 Make recognised evidence and assurance portable

Evidence and product-level assurance completed through recognised national routes, including the Innovator Passport, should be accepted across NHS organisations wherever relevant. Without a presumption of national acceptance, the Passport risks becoming another optional document alongside existing local processes. Additional review should be limited to genuine evidence gaps, changes in intended use or deployment-specific risks, with organisations required to explain why further checks are necessary.

RECOMMENDATION 4

BUILD STRUCTURED IMPLEMENTATION CAPABILITY AND CONTINUOUS LEARNING

Primary recommendation

Build NHS capability to embed and sustain apps and wearables in routine care. Implementation should have clear ownership, specialist expertise and continued support, with learning shared across organisations to improve delivery and support scale.

- Building on:** HIN regional functions, HRC expertise, NHS workforce-development activity and MedTech Compass.
- Gap:** Unclear ownership, reliance on champions and fragmented learning.
- Likely owners:** DHSC, NICE, NHS England, HRCs, HINs and NIHR
- ABHI role:** Convene, share implementation experience and initiate work where no owner exists.

4.1 Assess technology and system readiness together

Assess the receiving service alongside the technology, including infrastructure, workforce capacity, pathway fit and the ability to act on outputs. The assessment should identify support needs rather than create another approval gateway.

4.2 Establish recognised digital adoption roles and capability

Define digital adoption responsibilities at national, regional and local levels, ensuring the right clinical, procurement, integration and change-management expertise is available at each stage. Establish recognised roles, competencies and training, with regional specialist support where capability cannot be maintained locally, reducing reliance on informal champions.

4.3 Plan implementation before procurement

Require business cases and procurement plans to define necessary pathway and workflow changes, responsibilities for implementation and who will review and act on technology-generated information.

4.4 Embed digital capability in professional education

Include apps, wearables and patient-generated data in professional education and continuing development. Staff should understand how to use and interpret digital technologies, communicate their limitations and escalate concerns.

4.5 Prepare for consumer-generated wearable data

For regulated features, interpretation and response should reflect the product's intended purpose, risk classification and manufacturer information. The NHS should develop guidance for data from consumer products or uses outside established pathways, clarifying when information may be clinically relevant, how confidence in different forms of wearable information should be considered, what further assessment is required and where responsibility sits. The implications for service demand and inequalities should also be considered.

4.6 Monitor implementation and provide feedback

Monitor sustained use, outcomes, usability, equity and pathway impact after deployment, complementing rather than duplicating regulatory post-market surveillance. Patients and staff should have accessible routes to report concerns, with relevant findings shared with manufacturers, commissioners and regulators. Learning should inform product improvement, implementation support and recommissioning decisions.

PART 5

DELIVERY

Publication of this strategy will mark the start of ABHI's delivery activity. ABHI will use its role as the voice of the HealthTech industry to maintain momentum behind the recommendations, convene the organisations needed to deliver them and ensure that industry experience informs national and local implementation.

ABHI will not lead delivery of every recommendation. For each action, we will identify the organisations with the relevant mandate, expertise and delivery mechanisms, and seek to embed the recommendation within existing initiatives wherever possible. Where activity is already under way, ABHI will represent industry, influence its design and support delivery. Where no clear activity or owner exists, we will convene the relevant partners, establish a route forward and, where appropriate, lead initial action before transitioning ownership to the organisation best placed to deliver it.

ABHI's role will vary across the recommendations:

- Lead:** Initiate and coordinate activity that falls within ABHI's remit and where no suitable programme already exists.
- Convene:** Bring together the organisations needed to agree ownership, develop practical actions and resolve barriers.
- Influence:** Represent industry within existing national and local initiatives, ensuring that their design reflects implementation and commercial realities.
- Embed:** Identify opportunities to incorporate recommendations into established programmes rather than creating parallel structures.
- Hand over:** Transfer actions to organisations with the mandate and capability to deliver them, while continuing to monitor progress and represent member interests.

ABHI will:

- Represent industry:** Use member evidence and implementation experience to inform policy and the design of national initiatives.
- Convene delivery partners:** Bring together the organisations needed to agree ownership and practical next steps.
- Support practical delivery:** Help translate existing frameworks into useful guidance, share implementation learning and identify opportunities for adoption at scale.
- Maintain accountability:** Keep an actionable delivery plan setting out partners, milestones and indicators, and publish regular progress updates.

MEASURING SUCCESS

Progress should be measured through a set of indicators using existing data and reporting arrangements wherever possible. These should assess:



The time from evaluation to a commissioning or funding decision.



Uptake beyond the initial site and continued use after initial funding.



The reuse of evidence and assurance across NHS organisations.



Patient access, outcomes and equity.



The reduction in repeated pilots and local assessments.



Implementation readiness, including ownership, workforce capability & support.



Access to multi-year or sustainable commissioning arrangements.



Industry experience of navigating NHS routes and confidence in the UK market.

ABHI will publish regular progress updates setting out actions taken, changes achieved and barriers that remain. These should include learning from technologies that were not commissioned, did not scale or were withdrawn, as well as successful adoption. The ultimate measure of success will be whether more patients can access effective technologies, NHS organisations can implement them sustainably and companies have a clearer and more predictable route into routine NHS care.

PART 6: CASE STUDIES

OURA

Harnessing wearables for prevention: how Oura Members are taking a proactive role in their health.

Why prevention needs new infrastructure

Healthcare systems like the NHS were built to treat illness once it presents. That model is under strain. The World Health Organization projects a global shortfall of 11 million healthcare workers by 2030.¹ Meanwhile, nearly a third of adults worldwide — around 1.8 billion people — did not meet WHO-recommended levels of physical activity in 2022, raising their risk of cardiovascular disease, type 2 diabetes and dementia.²

Much of that burden is shaped by behaviour accumulating over years, so acting early both extends healthspan and lowers the cost of care. The difficulty is knowing who needs support, and when. Health has historically been measured in snapshots, and most people engage with the system only once symptoms are hard to ignore — by which point the window for low-cost intervention has narrowed. Technology earns its place here not by replacing the consultation, but by making what happens between them visible.

Helping people understand their own health

Oura Ring tracks more than 50 health and wellness metrics — including sleep stages, heart rate variability, respiratory rate, personalised temperature trends and activity — through research-grade sensors validated against medical gold standards. With up to eight days of battery life, it collects data quietly in the background, surfacing trends at the right moments.

Crucially, Oura Ring learns an individual’s own baseline rather than comparing them to a population average. A resting heart rate of 62 means little in isolation. One that has drifted five beats above someone’s personal norm for a fortnight could be a signal to have a conversation with a doctor.

Health Radar, developed with Oura’s 40+ in-house MDs and PhDs, brings the most important signals into one place.

Key features:

- **Symptom Radar** looks for signs of strain across temperature, respiratory rate, resting heart rate and HRV in a simple three-level estimate. It builds on the TemPredict study, in which an algorithm using Oura Ring data identified COVID-19 an average of 2.75 days before participants sought testing.³
- **Blood Pressure Signals** surfaces cardiovascular-related patterns from nighttime PPG data across 30-day assessment periods, alongside manually logged cuff readings.
- **Nighttime Breathing** gives a 30-day view of breathing regularity and sleep-related disturbances, patterns that have traditionally required an overnight sleep study.

These are general wellness features: they do not diagnose, treat or monitor any condition, and are not a substitute for clinical assessment.⁴ What they do is show someone when a change in their own data may be worth raising with a healthcare professional.

Bria, a 29-year-old dance coach, was on her honeymoon in Japan when Oura’s Symptom Radar feature began alerting her to major signs of strain in her body. Coupled with night sweats almost every night, initially, she chalked up her symptoms to lifestyle changes and stress.

Upon returning home, she saw a doctor who only suggested changing her diet and taking an antacid for the reflux. Trusting her intuition and her Oura data, Bria advocated for herself and insisted on an X-ray. A 12cm mass was found on her lung, and she was diagnosed with Stage 3 Non-Hodgkin’s Lymphoma.

That discovery set off a health journey the newlywed and her now-husband never expected to be on. Following lengthy treatment Bria recently received the life-changing news that she is cancer-free.

Bridging the gap between members and clinicians.

Data only creates value if it travels. In Oura’s own Member research, 51% report at least one chronic condition; of those, 48% have already shared or discussed their Oura data with a healthcare professional and 80% are open to doing so.⁵

For a clinician, that changes the starting point of a consultation. Instead of relying on recall, they have a longitudinal record of sleep, activity and cardiovascular trends, and a patient arriving with a specific question. Oura is not a diagnostic tool. It is a front door into a better conversation.

Nicole, a healthy and active 31-year-old, became anxious and burned out after six months of juggling work, travel, and training for her first half-marathon. This triggered severe illness and gastrointestinal issues that left her barely able to function.

Despite extensive testing and visits to top specialists, she was repeatedly misdiagnosed—with conditions ranging from early-onset MS to multiple autoimmune diseases to propofol infusion syndrome—until she brought her exported Oura data to a rheumatologist who was able to trace her decline in HRV, sleep, resting heart rate, stress, and readiness back to a routine endoscopy, ultimately revealing a mast cell reaction triggered by the anaesthesia used in that procedure.

45-year-old Saša began experiencing bloating, ovulation pain, shorter cycles, and heavy periods when she entered perimenopause about two years ago, and started using Oura’s Cycle Insights alongside her doctor’s guidance to monitor how her body was responding to hormone replacement therapy through body temperature trends. When she noticed no post-ovulation temperature rise one month—followed two days later by estrogen-dominance symptoms—she took the bioidentical progesterone her doctor had prescribed, and was then able to see the same temperature rise and physical symptoms on Oura that normally accompany ovulation and the shift into her luteal phase. This visibility into her own body’s patterns has left her feeling empowered.

Oura is building the evidence base behind this. The Oura–NUS Joint Lab, with the Centre for Sleep and Cognition at the National University of Singapore, extends a six-year collaboration into multi-year studies of how sleep and daily behaviour shape long-term health.⁶ Oura is also contributing 1,500 rings to Project RESET, Singapore’s cardiovascular prevention initiative, which is recruiting 3,000 participants aged 40 to 70.⁷

The research is international; the question is universal. Can continuous, validated data help people and their clinicians act while action is still cheap and effective? Oura Members are already showing what that looks like in practice — quietly, long before a symptom becomes a diagnosis.

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4 Oura, Health Radar feature disclaimer — <https://ouraring.com/health-radar> and <https://support.ouraring.com/hc/en-us/articles/52627030482707-Health-Radar>

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6 Oura, “Oura and National University of Singapore Open Joint Lab to Advance Research in Personalized Preventive Health” (January 2026) — <https://ouraring.com/blog/oura-and-national-university-of-singapore-joint-lab/>

7 Oura, “RESET Collaborates with Oura to Transform Preventive Cardiovascular Health Through AI-Powered Wearable Insights” (June 2025) — <https://ouraring.com/blog/reset-oura-cardiovascular-health-partnership/>

8 See note - All Health Radar features are intended for general wellness purposes only and are not intended to diagnose, treat, cure, mitigate, monitor or prevent any disease, illness or medical condition.⁹

SLEEPPIO INSOMNIA TREATMENT

Leveraging a NICE-recommended digital therapeutic to deliver nationwide access to first-line insomnia treatment.

How Scottish Government, NHS Scotland, and Big Health partnered to provide nationwide access to Sleepio, the NICE-recommended digital therapeutic for insomnia.

Tackling the challenge of insomnia

In 2020, Scotland recognised an urgent unmet need in insomnia. Insomnia is highly prevalent, affecting up to 14.4% of adults, and highly debilitating, doubling the risk of depression and increasing risk of anxiety, diabetes, hypertension, obesity, and suicidal ideation. It costs the UK economy c. £40 billion p.a. in lost productivity and increased healthcare costs, including 200,000 lost working days.

Yet access to first-line treatment, cognitive behavioural therapy for insomnia (CBT-I), was extremely limited in Scotland due to a lack of trained therapists. Even patients that could access CBT-I often waited over three months, however it was not feasible to recruit and train a new therapist workforce.

Partnership on the ground

Implementation was delivered jointly by Big Health, Scottish Government's Digital Mental Health Team (DMHT), and NHS teams working at national, regional, and local levels:

- Nationally, Sleepio was embedded in NHS 24, Scotland's multi-channel online health support service. Sleepio now features on NHS patient-facing websites and in public health campaigns.
- Regionally, Big Health delivered education sessions in partnership with Health Board leads across all 14 Health Boards. Sleepio is incorporated into local formularies and patient messaging templates. Awareness is promoted via Health Board social media channels.
- Locally, Big Health worked with the DMHT and local NHS teams to directly train primary care staff, charities, and advocacy groups, and supplied digital and physical resources to GP practices. Patients report being signposted to Sleepio by a broad mix of roles in primary care, from GPs and practice nurses to pharmacists, social prescribers, and link workers.

Outcomes

Sleepio has given all citizens instant access to first-line treatment. >100,000 people have accessed Sleepio to date. Roughly 50% have accessed Sleepio after speaking with a healthcare professional and 50% via self-referral, freeing up in-person services for those who need them. Real-world outcomes are consistent with RCT data, which show that up to 76% of people experience clinically meaningful improvement after using Sleepio, with studies showing long-term benefits up to 3 years.

By centrally commissioning Sleepio, Scottish Government provided nationwide access to CBT-I for c. 8% of the cost of face-to-face delivery. (This excludes costs associated with hiring and training the therapist workforce, so true cost is significantly lower than 8%.)

By contrast, Sleepio is not yet available in England. Evidence suggests that NHS England has missed out on at least £100 million in cost savings as a result, not including the broader economic costs of failing to adequately treat insomnia. NHS England is currently exploring a nationwide approach to digital CBT-I.

John Swinney, First Minister of Scotland, referenced the success of digital treatments in his speech on improving public services and NHS renewal:

“Building on the already successful model of digital support for mental health – a service that saw 74,000 referrals in 2023-24 – we will offer support in additional areas including dermatology and the management of long-term conditions. This type of care, because it is not dependent on physical attendance, at a specific time, in a specific place, is more flexible. It means care can be made to fit better into the lives of those who use the services. Again, smarter care, and better care.”

Patient voice

Brian, 62, based in East Lothian, works as a trainer for a mental health charity in Scotland.

“Insomnia made it almost impossible to work productively. When you’re getting just two or three hours of sleep a night, you can’t function properly the next day. I still turned up at work – but I wasn’t really there. I couldn’t concentrate, I was irritable, and I started making rash decisions. My productivity went through the floor. I work in mental health, so I feel a great sense of responsibility to be on top of my game. People depend on me. If I make mistakes at work, it has a direct impact on other people’s lives.”

Brian tried various sleep hygiene regimes without success, and took sleeping pills for a while, knowing they were no long-term answer. He eventually went to his GP.

“My GP said there’s this new treatment that’s come out. It’s called Sleepio. It’s an app. It’s on your phone, or you can use it on your laptop. And it will help you train your brain to get back to good sleeping.”

Brian was surprised by some of the advice, but quickly found it was working.

“Sleepio was asking me to go to bed later and get up earlier. I thought, ‘I’m already not sleeping and you’re going to get me less sleep. That doesn’t make sense!’ But the programme was right. It was exactly what I needed to rebuild my sleep from scratch.

His advice to people new to Sleepio is to stick with it, as it takes time to change stubborn poor sleep.

“You need to create those new brain habits. So the six weeks of the programme is a really good thing. Keep going with it, even if you have hiccups along the way. Halfway through, I did have a little bit of a hiccup and then just went back to the basics again, and that got me right back on track. Persevere with it. I can’t emphasise that enough.”



References

14.4% prevalence: [Tse et al., 2026](#)
Insomnia as a risk factor: [NICE Insomnia CKS](#)
£40M cost of insomnia: [RAND., 2023](#)
3+ month wait times for CBT-I: [NICE Guidance in Development](#)
Sleepio access rates: Internal Big Health data
Clinical outcomes for Sleepio: [Espie et al., 2012](#); [Tarnai et al., 2025](#); [Prather et al., 2025](#)

Durability data for Sleepio: [Luik et al., 2020](#); [Cheng et al., 2021](#)
Sleepio recommended as first-line; Sleepio costing 8% of the cost of in-person CBT-I delivery calculated based on Sleepio cost £45 / in-person cost £542 = 8.3% Costs from 3.7 on p. 11; [NICE HTG624](#)
Missed cost savings of £100M for NHSE: [Sampson et al., 2022](#)
NHS England digital CBT-I tender: [NHSE Digital CBT-I Tender](#)
John Swinney referencing the success of digital treatments: <https://www.gov.scot/publications/improving-public-services-and-nhs-renewal-first-ministers-speech/>

SQUEEZY CONNECT

Supporting the implementation of women's health app Squeezy Connect in Dorset.

Overview

Health Innovation Wessex (HIW) supported NHS Dorset to adopt Squeezy Connect within the Dorset Women's Health Programme. The digital pelvic-health tool was embedded in a wider pathway combining workforce education, early identification, self-management, signposting and specialist referral. HIW provided innovation scanning, due diligence, pathway mapping, data protection and contracting support, implementation expertise and evaluation.

Challenge

Pelvic floor dysfunction is common, yet timely support is limited. RCOG data indicates that more than 60% of UK women report at least one symptom of poor pelvic floor health. Many do not seek help or know how to perform pelvic floor exercises because of embarrassment, limited awareness or the belief that symptoms are normal.

Response

NHS Dorset funded Squeezy Connect licences for women at risk of, or experiencing, pelvic floor dysfunction. The app provides guided pelvic floor exercise support and reminders. It was implemented alongside professional training, clinical conversations, the Our Dorset women's health resource, and onward referral where required.

Implementation

Following a locally led innovation scan and clinical shortlisting, HIW completed regulatory, data-protection and contracting due diligence and supported pathway design and adoption. Two train-the-trainer sessions equipped clinicians already undertaking vaginal examinations—including sexual-health and general-practice staff—to identify need, provide opportunistic support and refer women to Squeezy. Clinical recommendation proved important: women were more likely to download the app when it was endorsed by a healthcare professional.



Impact



More than **170 women** gained access to NHS Dorset-funded Squeezy Connect licences.



16 community and primary-care colleagues received initial training, cascaded to **30 additional staff**.



The training model spread to **Milton Keynes University Hospital**, where it was rolled out further.



Women **valued** the app's exercise reminders; practitioners reported greater **confidence** discussing pelvic-floor health and signposting to support.

Learning and success factors

Free access alone did not secure adoption: awareness, confidence, convenient access routes and trusted clinical recommendation also mattered. Squeezy connect worked best as part of a pathway rather than as a standalone app. Success depended on system leadership, clinical ownership, workforce education, implementation expertise, monitoring of uptake and real-world evaluation.

Scalability

The model is transferable: identify and assess an innovation, integrate it into an agreed pathway, build workforce capability, monitor uptake and refine delivery using real-world evidence. Spread to Milton Keynes University Hospital demonstrates potential beyond Dorset, with further scale being explored.

References

Dorset Women's Health Programme Impact Report (February 2026)

Independent programme evaluation (January 2026)

Train-the-trainer evaluation (February 2025)

ANNEX

ITEM 1: SCOPE AND DEFINITIONS

This strategy covers software applications and body-worn devices used by individuals to understand, manage or treat their health, whether or not they are regulated as medical devices.

It focuses on how these technologies reach routine use in the NHS in England, although many of the regulatory and evidence issues apply across the UK. It does not address clinician-facing software such as electronic patient records or monitoring equipment used only within clinical premises.

The regulatory, evidence and post-market requirements applying to these technologies differ according to their intended purpose, claims and level of risk. Recommendations in this strategy should therefore be applied proportionately. Measures intended to improve transparency around consumer products will not necessarily be appropriate for regulated medical devices and IVDs, which already operate within established regulatory frameworks.

These categories are not always distinct in practice, and a product may move between them as its claims or functionality change. Where this strategy refers to apps and wearables, it means all four categories. Recommendations directed at a particular category are identified as such.

- **Wellness and lifestyle products.** Apps and devices that support general health awareness, such as activity, sleep or nutrition tracking, without a medical purpose. They sit outside medical device regulation and the evidence supporting their claims varies widely.
- **Consumer wearables with health features.** Mainstream devices, typically smartwatches or rings, that combine wellness functions with specific features regulated as medical devices, such as irregular rhythm notification. Regulatory status applies to the individual feature rather than the whole device.
- **Regulated apps.** Software with a medical purpose, including digital therapeutics and digital assessment tools. Classification depends on intended purpose and risk, and these products must meet UK medical device requirements before being placed on the market.
- **Medical-grade wearables.** Body-worn devices supplied for a defined clinical purpose, such as continuous glucose monitoring or cardiac rhythm monitoring, with validated measurement performance and an intended role in clinical decision-making and evidence demonstrating their ability to support safe and effective care.

ITEM 2: METHODOLOGY

1. Scope and approach

The strategy was developed through a qualitative programme of stakeholder engagement, supported by a review of relevant policy, research, official data and national initiatives. It explored how apps and wearables are developed, regulated, evaluated, commissioned, implemented and scaled within the NHS, with particular attention to mental health, women’s health and long-term condition management.

The findings represent a synthesis of stakeholder experience and supporting evidence, rather than a quantitative or representative assessment of the whole UK market.

2. Stakeholder engagement

Most engagement was undertaken with health applications and wearable technology companies, both consumer and medical grade. Participants included ABHI members and non-members and represented different product types, clinical use cases, stages of market maturity and experiences of navigating routes into the NHS.

Industry engagement was complemented by two workshops coordinated by the [NIHR HealthTech Research Centre Network](#). The workshops brought together expertise from across clinical, research, evaluation and implementation settings and made a substantive contribution to the strategy, particularly its approach to needs-led evaluation, proportionate evidence, system readiness and clinically actionable data.

Targeted discussions with national policy, regulatory, evaluation, NHS, research and wider system stakeholders provided further perspectives and helped test the emerging analysis. Stakeholders were identified through an initial mapping exercise, existing networks and recommendations arising from earlier discussions. Identification continued throughout the project to respond to emerging themes and gaps in representation.

3. Evidence was gathered through:

- 41 targeted interviews and stakeholder discussions;
- written evidence and supporting materials;
- an industry validation workshop (3 hours);
- two NIHR HRC workshops (2 x 2 hours); and
- iterative review of emerging findings and recommendations.

Interviews explored experiences across the adoption journey, how technologies were being used in practice and the changes required to support routine use and wider scale.

The industry workshop tested the emerging findings with companies developing and deploying apps and wearable technologies. Participants validated the principal barriers and refined the recommendations, with particular emphasis on reimbursement, fragmented commissioning, repeated local processes, implementation capability and the lack of a clear route from successful evaluation to routine use.

The HRC workshops examined the emerging findings from research, evaluation and implementation perspectives. Their input strengthened the recommendations by ensuring they considered both the quality of the technology and the ability of patients, pathways and NHS organisations to use it effectively.

4. Analysis and validation

Interview notes, transcripts, workshop outputs and written submissions were reviewed thematically and organised around the journey from identifying need to sustained NHS use. Greater weight was given to themes that recurred across multiple discussions or stakeholder groups or identified a significant risk or gap. Observations arising from a limited number of discussions were treated as illustrative insights rather than sector-wide conclusions.

Emerging findings and recommendations were refined iteratively. Industry emphasised the need for clearer commercial routes, reduced duplication and sustainable commissioning. The HRC workshops reinforced the adoption challenge while broadening the analysis to consider how technologies are evaluated and used in practice.

5. Use of published evidence

Published research, official statistics and national guidance were used to test and contextualise stakeholder observations, support quantitative claims and identify relevant policy and international approaches. External evidence was used particularly within the mental health, women’s health and long-term condition use cases, and in relation to regulation, evidence standards and reimbursement.

6. Attribution and confidentiality

Insights from interviews and workshops have generally been synthesised, rather than attributed to individuals. Company examples have been included only where appropriate or agreed through the case-study process. While there was strong consensus across industry on many of the key issues and challenges identified, the findings should not be interpreted as representing the views of every participant or organisation involved.

7. Limitations

The engagement was qualitative and purposive rather than a representative survey. As most participants were technology companies, the findings provide particularly strong insight into industry experience of developing products and navigating routes into the NHS.

The HRC workshops provided broad, multidisciplinary input from across the NIHR HRC Network. Commissioners, finance and procurement leaders, frontline professionals, patients and carers were less extensively represented. Continued engagement with these groups will therefore be important during implementation.

Apps and wearables also vary substantially in intended purpose, risk, evidence maturity and route to market. The findings should therefore be understood as cross-cutting themes rather than requirements that apply identically to every technology or pathway.

ITEM 3:
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ABHI would like to thank the companies, NHS stakeholders, national bodies, researchers, evaluators, charities and other organisations that contributed their time, evidence and experience to the development of this strategy.

This included ABHI members and non-members, participants in targeted discussions and the companies that contributed to the industry validation workshop.

ABHI particularly acknowledges the contribution of the NIHR HealthTech Research Centre Network, which coordinated two workshops involving representatives from:

- NIHR HRC in Accelerated Surgical Care
- NIHR HRC in Brain Injury
- NIHR HRC in Cardiovascular and Respiratory Medicine
- NIHR HRC in Devices, Digital and Robotics
- NIHR HRC in Diagnostic and Technology Evaluation
- NIHR HRC in Emergency and Acute Care
- NIHR HRC in In Vitro Diagnostics
- NIHR HRC in Long-Term Conditions (Devices for Dignity)
- NIHR HRC in Mental Health (MindTech)
- NIHR HRC in Paediatrics and Child Health
- NIHR HRC in Rehabilitation
- NIHR HRC in Sustainable Innovation

Representatives attended one or both workshops and provided insights from across clinical, research, evaluation and implementation settings. Their multidisciplinary expertise provided important challenge and depth to the strategy’s findings and recommendations.

ABHI also thanks those who reviewed and challenged the emerging findings and recommendations. Their input helped ensure that the strategy reflects both the practical experience of industry and the requirements of responsible, evidence-based NHS adoption.

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Association of British HealthTech Industries
Suite 2, 4th Floor, 1 Duchess Street,
London, W1W 6AN

A company limited by guarantee.
Registered in England no. 1469941. Registered office as above.

+44 (0)20 7960 4360
enquiries@abhi.org.uk
www.abhi.org.uk

 uk.linkedin.com/company/abhi