BRIEFING · AUGUST 2026

Artificial Intelligence in *UK Insurance Claims*

What the evidence actually says, what the regulator expects, and what can safely be done now.

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Prepared as a market briefing. Every figure is traced to a regulator, a trade body, the Financial Ombudsman, published legislation, or an insurer speaking on its own record.

ONE

A note on the numbers

Most published statistics about AI in claims are produced by companies selling AI for claims.

Repeating those figures is the fastest way for a briefing to lose its authority. They are precise, quotable and almost never sourced. Trace them back and they end at a marketing page with no methodology, no sample and no named organisation.

So this document sets a rule for itself. Everything here is traced to a regulator, a trade body, the Financial Ombudsman, published legislation, or an insurer speaking on its own record. Where a figure could not be traced to one of those, it has been left out — including several that would have made the argument look considerably stronger.

INCLUDED

Named, primary sources

The FCA, the Bank of England, the ABI, the Financial Ombudsman Service, UK and EU legislation, and insurers' own published statements.

EXCLUDED

Unsourceable claims

Six widely-quoted claims-AI statistics were dropped, including one that names three UK insurers on an operational metric no public disclosure supports.

FLAGGED

Where evidence stops

Where no credible UK benchmark exists, this document says so rather than borrowing a number from a different market.

What was left out, and why it matters

The excluded figures are worth naming, because you will meet them. Claims resolved seventy-five per cent faster. Processing costs cut from twenty-two dollars to three. First notification to triage falling from eight hours to five minutes. Three named UK insurers reported as running motor claims automation above sixty per cent.

Every one of those traces to a vendor blog. The last is the most dangerous, because naming real firms on an unverifiable operational metric is precisely the kind of error that ends a relationship before it starts.

One figure was excluded after checking rather than before. A sixty-million-pound saving attributed to Aviva's motor claims programme circulates widely. It does not appear in the published case study for that programme, nor in Aviva's own materials. The operational outcomes from the same programme are properly sourced and appear later in this document. The financial figure does not.

THE POSITION

Stated as at 2 August 2026. Two items in this document changed within the fortnight before it was written — one of them five days before.

TWO · CONTEXT

The wider insurance market

This is not a sector in trouble. The pressure is concentrated in one part of it.

300,000+
people employed in UK insurance

86%
of consumers hold at least one general insurance or pure protection product

$187bn
London Market gross written premiums, up 17% since 2022

£61bn
contribution to UK GDP, and 37% of City GDP

Source: FCA, Regulatory Priorities: Insurance, February 2026.

The London Market has doubled in size in ten years and remains internationally competitive in both retail and wholesale lines. Capital is not short. Premium income has grown. By most measures available to a board, the market looks healthy.

What is under strain is the part of the business the customer actually experiences. A person buys insurance and then, mostly, forgets about it. The moment that decides whether the product was worth having is the claim — and that is where cost, complexity, complaint volume and supervisory attention are all rising at once.

It is also, this year, where the regulator has chosen to look. The FCA's February 2026 Regulatory Priorities report — the document that replaced more than forty portfolio letters — names improving claims handling as the first of four priorities for the insurance sector.

> WHY THIS FRAMING MATTERS
>
> A briefing that opens on crisis invites scepticism, because the market data does not support it. A briefing that opens on a healthy market with one concentrated pressure point is both accurate and more useful, because it points at where work is actually needed.

THREE · CONTEXT

The claims market

Claim costs are rising. Prices are not.

Motor

Motor insurers paid £11.9bn across 2.5 million claims in 2025. Damage to vehicles accounted for nearly £7.5bn of that — sixty-three per cent of everything paid. The second quarter of 2026 was a record: £3.2bn, five per cent up on the previous quarter and seven per cent up on the same period a year earlier.

The average motor claim payout reached £4,900, up four per cent in a single quarter. Windscreen repair alone rose seven per cent in three months, to an average of £283.

Premiums have not followed. Average motor cover fell through 2025, ending the year at £564 — nine per cent below 2024. It has since risen £6 to £566, which after inflation leaves it £14 below where it stood a year earlier.

Property

Property insurers paid £6.1bn in 2025, the highest annual total since the ABI began collecting the data. Home insurance accounted for almost £3.4bn across more than 560,000 claims, with the average claim rising fifteen per cent — close to £800 — to around £6,000. Average combined buildings and contents cover fell £14 over the same period.

The two drivers behind it

DRIVER ONE

Weather

Weather-related property claims reached £1.2bn in 2025, up fourteen per cent. Domestic flood claims rose thirty-eight per cent to £312m, and the average payout to a flooded homeowner rose sixty per cent to £30,000. Storm damage to homes rose thirty-two per cent. Subsidence reached a record £307m after the UK's hottest summer on record.

DRIVER TWO

Vehicle complexity

The ABI attributes rising motor claim costs directly to the complexity of modern vehicles — sensors, cameras, driver assistance systems and high-value components that are expensive to repair or replace, on supply chains that are still tight.

Neither driver responds to sharper negotiation or tighter process. Both increase the volume of work and the difficulty of each piece of it. Surge capacity has stopped being an exception process and become a permanent requirement, and damage assessment now demands more expertise per claim than it did five years ago.

THE CONSEQUENCE

Every pound spent handling a claim is under harder scrutiny than at any point in the last decade. That is the commercial pressure creating the AI conversation — and it is also the reason rushing it is dangerous.

Sources: ABI motor claims data, 11 February 2026 and 30 July 2026; ABI property claims data, 17 February 2026; Met Office. The ABI notes that its Q4 2025 motor collection improved market coverage against 2024, so absolute year-on-year totals should be treated with care; relative measures such as average claim cost remain representative.

What the industry is facing

Complaints are moving against the market trend

Complaints about car and motorcycle insurance to the Financial Ombudsman rose to 4,100 in the first quarter of 2026/27, up from 2,800 in the same quarter a year before. The issues consumers raised were claim values, policy cancellations and claim delays. Travel insurance complaints rose thirty per cent, with declined claims the most common cause.

Over exactly the same period, total complaints to the Ombudsman across all financial products fell — from 68,000 to 53,600. Insurance is rising against a falling tide. That is not noise.

The regulator has named it

The FCA's position is blunt: insurers provide vital protection when things go wrong, but too many people have poor experiences when they make a claim. Behind that sentence sit supervisory and enforcement investigations into home and travel claims handling, a response to the Which? super-complaint published in December 2025, and a widened review of outsourced and delegated authority claims — now including remuneration arrangements — reporting in early 2027. Work on motor total loss claims will result in around 270,000 drivers receiving compensation.

The judgement is leaving the building

The Chartered Insurance Institute estimates that a quarter of the insurance sector is due to retire within ten years. Against that, only four per cent of young people consider a career in insurance appealing; Aviva research cited in the same report found that of a thousand students surveyed, one in seven were interested in insurance, against one in three for technology.

> *The people who settle a complex claim are close to leaving, and the queue behind them is not forming. Capacity that walks out of the door does not come back through a recruitment campaign.*

This, more than cost, is the honest reason for a claims function to be looking seriously at AI. Framing it as a cost programme invites resistance from the very people whose judgement the function depends on. Framing it as a capacity and capability question is both more accurate and more likely to survive contact with the claims floor.

Sources: Financial Ombudsman Service quarterly complaints data, 22 July 2026; FCA, Regulatory Priorities: Insurance, February 2026; Chartered Insurance Institute, The Talent Shortage Crisis, April 2024.

The challenges of using AI

Insurance leads UK financial services on adoption. It does not obviously lead on control.

The most recent published joint survey by the Bank of England and the FCA covered 118 firms. It is worth being precise about its age: it was published in November 2024, and a new survey was in the field until the end of July 2026 with results expected before the year closes. A great deal of commentary presents the 2024 figures as current.

95%
of insurers already use AI — the highest of any financial services sector, ahead of international banks at 94%

2%
of use cases across financial services are fully autonomous; 55% involve some automated decision-making

46%
of firms report only partial understanding of the AI they use, against 34% claiming complete understanding

73%
share of all reported cloud provision held by the top three providers; 44% of models, 33% of data

Source: Bank of England and FCA, Artificial intelligence in UK financial services, 2024 survey.

General insurance is the third largest business area for AI use cases across the sector, at ten per cent of the total, behind operations and IT at twenty-two per cent and retail banking at eleven. Firms expect the median number of use cases to more than double within three years, from nine to twenty-one.

Three findings deserve more attention than they usually get. Forty-six per cent partial understanding is not a confidence problem; the survey attributes it mainly to third-party models, which is to say firms do not fully understand what they have bought. Eighty-four per cent of firms report a named accountable person for their AI framework, but accountability typically splits across three or more people or bodies — and under the Senior Managers regime, accountability shared is accountability unclear. And the risks firms expect to grow fastest are third-party dependencies, model complexity, and embedded or hidden models.

Four risks that behave differently inside claims

01	**Data, before models**	Four of the top five reported AI risks across the sector are data risks — privacy, quality, security, and bias. Most claims AI failures are data failures wearing a model's clothing.
02	**Explainability under challenge**	A claims decision has to survive a complaint, an Ombudsman referral and possibly a court. "The model said so" is not a defence in any of those three rooms.
03	**Concentration and lock-in**	A third of use cases sit with third parties, up from seventeen per cent in 2022, and provision is concentrated in a handful of firms. The Treasury Committee has recommended designating major AI and cloud providers as critical third parties.
04	**The asymmetry nobody prices**	An error that underpays or delays a genuine customer is a conduct breach. An error that overpays is a cost problem. They are not the same risk and should not share a single tolerance — yet most claims accuracy reporting nets one against the other.

SIX · CHALLENGES

The threat side

The first mover on generative AI in UK claims was not the insurer.

In June 2026 Allianz UK published a set of cases from its own fraud detection work. They are worth reading in detail, because they are the clearest public evidence of what has already changed.

- → A business owner's van, photographed on a social media page with the numberplate visible. A claim was pursued in his name for an accident that never happened, supported by images of his vehicle with a cracked front bumper added through AI photo editing and a false repair invoice for around £1,000. It was caught because the image was identical to the one on social media.
- → A Mercedes advertised for sale online, used to fabricate a staged-accident claim. A similar-looking car was used, with AI applied to change the numberplate.
- → An £80,000 escape-of-water claim supported by a photograph of a submerged kitchen floor. Analysis flagged ripple effects that behaved inconsistently and reflections that did not match the cabinets. The kitchen had never flooded and the repair invoices were fake.
- → An AI-generated driving licence submitted with a motor policy application, on a stolen identity.
- → A customer who believed they held a genuine policy, sold AI-generated documents by a ghost broker, driving entirely uninsured.

Fabricated images of watches, jewellery, insurance documents and flooded property have been attempted across both personal and commercial lines. Allianz reports combatting more than 34,200 fraud cases worth close to £174m over the year, having detected £92.6m in the first half of 2025 alone — thirty-four per cent up on the same period the year before.

Accompanying research found that fifty-two per cent of UK drivers have posted a photograph of their car online, and seventy-three per cent had no idea it could expose them to insurance fraud.

THE CAPABILITY GAP

Verifying that a photograph, an invoice or a document is genuine is now a claims capability in its own right. Most operating models do not have one, and most AI strategies do not mention it.

Set this beside the industry-wide picture. The most recent published ABI data records £1.16bn of detected fraudulent general insurance claims in 2024, across more than 98,400 claims — a twelve per cent rise in volume on the previous year. Motor accounted for fifty-three per cent of detected claims fraud. The 2025 annual figure has not yet been published.

Sources: Allianz UK, 5 June 2026 and 22 September 2025; OnePoll survey of 2,000 UK car owners for Allianz UK, May 2026; ABI detected fraud data for 2024, published 17 November 2025.

The position in the United Kingdom

There is no UK AI Act. That is not the relief it sounds like.

As at August 2026 there is no standalone UK AI legislation and no AI Bill before Parliament. AI is regulated through existing regimes. The FCA states its own position without ambiguity:

> *We do not plan to introduce extra regulations for AI. Instead, we'll rely on existing frameworks, which mitigate many of the risks associated with AI.*

Boards routinely read that as a lighter burden. It is closer to the opposite. It means every existing obligation applies in full to an AI-assisted decision, with no AI-specific exemption, no transitional period and no separate rulebook to point at.

Consumer Duty	Products and services must meet the needs of target customers and provide fair value; communications must meet customers' information needs. The FCA expects firms to monitor the outcomes customers actually receive, not merely to deploy carefully.
ICOBS	Claims must be handled promptly and fairly, and must not be unreasonably rejected.
Senior Managers Regime	A named individual is accountable for outcomes, including those produced by a model or by a vendor's model. Under review with the Treasury and the PRA through the first half of 2026.
Operational incident and material third-party reporting	New FCA and PRA rules following CP24/28, being introduced through the first half of 2026, with an implementation period.

The change most firms have missed

Section 80 of the Data (Use and Access) Act 2025 came into force on 5 February 2026. It replaced Article 22 of the UK GDPR, and it materially changed what is permitted.

The previous prohibition on solely automated decisions with significant effects became a safeguards regime. Such decisions are now permitted for most personal data, provided four safeguards are in place: the person must be informed a decision of that kind was taken, must be able to make representations about it, must be able to obtain human intervention, and must be able to contest it. Special category data — which in claims means medical and injury evidence — remains subject to stricter control.

A decision is "solely automated" where there is no meaningful human involvement. What counts as meaningful has not yet been defined; ICO guidance is still developing.

WHAT THIS ACTUALLY MEANS

The legal barrier came down. The evidential burden went up. Very few claims operations could currently produce, for any AI-assisted decision, the explanation, the record of genuine human involvement, and the route by which the customer could contest it.

The FCA is running a review of AI in insurance through 2026, explicitly assessing how firms use AI in underwriting, claims and services to consumers. In January 2026 the Treasury Committee criticised regulators for a wait-and-see approach and recommended clearer guidance on how existing rules apply, AI-specific stress testing, and designation of major AI and cloud providers as critical third parties.

Sources: FCA, AI and the FCA: our approach, updated 13 February 2026; FCA, Regulatory Priorities: Insurance, February 2026; Data (Use and Access) Act 2025, s.80; House of Commons Treasury Committee, AI in financial services, 20 January 2026.

Beyond the United Kingdom

The European Union

Under the EU AI Act, AI used for risk assessment and pricing in life and health insurance is classified as high-risk under Annex III. Claims handling is not itself on that list. The distinction is frequently got wrong in industry commentary and is worth stating plainly to any board that writes EEA business.

The deadline moved. The Digital Omnibus on AI is now law — Regulation (EU) 2026/1744, adopted by the European Parliament on 16 June 2026 and the Council on 29 June, published in the Official Journal on 24 July and in force from 27 July 2026. High-risk obligations for standalone Annex III systems move from 2 August 2026 to 2 December 2027; for systems embedded in regulated products under Annex I, to 2 August 2028. The Omnibus also adds a new prohibition covering AI-generated non-consensual intimate imagery and child sexual abuse material. Transparency obligations under Article 50 and the AI literacy duty under Article 4 are unaffected.

Most boards diarised 2 August 2026. It moved five days before this document was written. That buys planning time; it does not remove the obligation.

Separately, EIOPA's Opinion on AI governance and risk management, published in August 2025, introduces no new rules but interprets existing insurance legislation — Solvency II, IDD, DORA and GDPR — for AI use across the whole value chain, claims included. It binds supervisors in the EEA rather than the UK, but it remains the clearest published statement anywhere of what a supervisor expects good AI governance in insurance to look like, and a UK firm can reasonably adopt it as a benchmark.

What the courts have said

The following concerns United States litigation over products with no UK equivalent. It is not UK law and should not be presented as such. Its value is as a governance signal.

Class actions filed in November 2023 challenged the use of algorithmic tools in health insurance claim denials. In February 2025 a court allowed claims for breach of contract and breach of the implied covenant of good faith to proceed. In March 2025 a second court found that an insurer's interpretation — under which a medical director pressing a button on an algorithmic output satisfied the requirement for medical-necessity review — conflicted with the plain language of the plan and amounted to an abuse of discretion. In March 2026 a court ordered disclosure of the algorithm itself.

> *A human rubber-stamping a model's output is not human review. One jurisdiction has already said so. UK law now requires meaningful human involvement without yet defining it.*

Sources: Regulation (EU) 2026/1744, Official Journal 24 July 2026; EIOPA Opinion on Artificial Intelligence governance and risk management, EIOPA-BoS-25-360, 6 August 2025; US federal court rulings, 2025 and 2026.

Today: what can be done now

Seven things that are deployable under current UK rules, ordered by regulatory friction, lowest first.

01	**Document and evidence summarisation**	Medical reports, engineer reports, policy wordings and correspondence bundles compressed for a human who still makes the decision. Aviva's life underwriting tool is the clearest published UK precedent.
02	**Intake and triage support**	Structuring an unstructured notification and routing it to the right team. Routing is not a claims decision, and getting it right first time removes rework downstream.
03	**Evidence integrity checking**	Detecting manipulated or synthetic photographs, invoices and documents. A new defensive capability answering a verified and growing threat, with no conduct downside.
04	**Fraud detection and prioritisation**	Established practice across the UK market. Referral for human investigation, never automated denial.
05	**Claims handler assistance**	Call summarisation, next-best-action prompts and wrap-up. Better file notes are themselves a conduct control, and the time released is real.
06	**Complaint and vulnerability signals**	Early detection of poor outcomes and of customers in vulnerable circumstances. Turns an FCA expectation into a working early-warning system.
07	**Repair and supply chain analytics**	Attacks the cost driver the ABI identifies without touching a customer-facing decision.

> THE COMMON FEATURE
>
> None of these hands a claims decision to a machine. Each of them either prepares work for a person, protects the firm, or acts on something that is not a claims decision at all. That is why they are defensible today, and why they are the right place to build the governance muscle needed for anything more ambitious.

Tomorrow: three levels

Assistive, augmentive, adaptive — a ladder of accountability rather than a ladder of technology.

These three words are used loosely across the industry, usually to describe how clever a system is. That framing is not much use to a board. Defined by where accountability sits, they become a decision a board can actually take.

LEVEL ONE

Assistive

The system prepares, summarises and surfaces. The person decides. Accountability is unchanged, and almost all defensible value sits here today.

LEVEL TWO

Augmentive

The system recommends a decision, with its reasoning and its confidence, inside defined bounds. The person confirms, overrides or escalates, and the override is captured. Accountability still sits with the person — but the review has to be demonstrably meaningful, which is both the Data (Use and Access) Act test and the test a court has already applied elsewhere.

LEVEL THREE

Adaptive

The system decides within a defined envelope and adapts as conditions change. Human oversight moves from the individual decision to the envelope itself. Accountability moves to whoever sets and monitors that envelope. This requires governance maturity that very few claims functions currently have.

Near, medium and long term

HORIZON	WHAT BECOMES POSSIBLE
Now *0–12 months*	Summarisation, triage support, evidence integrity, fraud referral and handler assistance — industrialised properly rather than piloted. Settlement-range recommendation on low-value, high-volume claims, with human confirmation and the override recorded.
Next *12–36 months*	Liability assessment support, reserve recommendation and supply chain routing. Narrow automated settlement on tightly bounded claim types, with explanation, human intervention and contest routes instrumented from the start rather than retrofitted.
Later *36 months +*	Assistive capability assumed as a baseline. Support extending into complex and specialty claims. Portfolio-level routing and capacity allocation adapting under supervised limits, with the board setting the envelope.

AN HONEST CAVEAT

No UK insurer is publicly operating at the adaptive level in claims today, and only two per cent of AI use cases across UK financial services are fully autonomous. The third horizon is a reasoned projection, not an observation. Any document that presents it as inevitable is selling something.

ELEVEN

Benefit realisation

Decide how benefit will be measured before anything is deployed, not after.

There is very little verifiable, insurer-published UK benefit data for claims AI, and that absence is itself the finding. Aviva's own release on its underwriting summarisation tool — the most transparent public statement by a UK insurer on this — quantifies nothing beyond "significantly improving turnaround times". Insurers are markedly more willing to publish fraud detection numbers than efficiency numbers.

The one substantial worked example

Aviva's claims programme is documented in a published case study by the consultancy that delivered it, quoting Aviva's Chief Claims Officer for UK General Insurance on the record — a materially higher standard of evidence than a vendor blog, and materially lower than a regulatory disclosure. It should be cited as what it is.

> REPORTED OUTCOMES
>
> More than 80 AI models deployed across the claims lifecycle, from first notification to settlement. The average time to assess liability on complex cases fell by 23 days. Routing accuracy improved 30 per cent. Customer complaints fell 65 per cent and Net Promoter Score improved more than sevenfold. Employee engagement more than doubled to an all-time high. Over 40,000 hours of training were invested, and use of recycled parts tripled.

Two design choices in that programme matter more than any of the numbers. The claims journey switches between digital and human handling depending on which produces the better outcome — and in cases involving personal injury it defaults to human interaction. That is a deliberate, designed limit on automation in the highest-stakes claims. Second, every tool had to prove its worth, and the firm was willing to revert to non-digital handling where that was better. A reversion path is a governance control, not an admission of failure.

It is also worth noting what the programme did to the workforce. Adjusters moved away from assembling data and routine routing, toward complex and contested cases — which is the answer to the question a claims director will be silently asking throughout any AI conversation.

What to measure

WHERE BUSINESS CASES BREAK

Netting underpayment against overpayment hides a conduct breach. A fraud model that catches more while investigating more honest claimants has made things worse. Both look like success on a conventional dashboard.

- → **Cycle time** — notification to decision, and decision to settlement, by claim type and complexity band.
- → **First-time-right** — reopened claims, re-routed claims, corrected decisions.
- → **Indemnity accuracy, counted separately in both directions** — underpayment is a conduct issue, overpayment a cost issue; a netted figure conceals both.
- → **Conduct outcomes** — complaint rate and reason, uphold rate, Ombudsman referral rate, and differentials for vulnerable customers.
- → **Fraud detection rate *and* the cost of false positives** — a model that catches more fraud while investigating more honest claimants has made things worse, and most reporting will not show it.
- → **Capacity released, and where it went** — released capacity that is not consciously redeployed is not a benefit.
- → **Contestability** — can the firm produce, for any AI-assisted decision, the explanation, the human-involvement record and the route to contest?

TWELVE

A way in

Eight pieces of work, in the order in which they make sense.

This is written so that it could be acted on without outside help. The sequencing matters more than the labels: the first three establish where the organisation actually stands, and everything after follows from what they find.

#	WORKSTREAM	OUTPUT	DURATION
01	**Claims AI readiness assessment**	A scored baseline across data, process, governance, skills, technology and the existing supplier estate, with prioritised gaps.	4–6 weeks
02	**Use case identification and triage**	Candidate uses mapped to the assistive / augmentive / adaptive ladder and to conduct risk, producing a ranked portfolio and a defensible "not yet" list.	3–4 weeks
03	**Regulatory and legal position paper**	Consumer Duty, ICOBS, the Senior Managers regime, DUAA section 80 and any EU exposure, with named accountabilities rather than a general summary.	3–4 weeks
04	**Board and executive governance**	Decision rights, risk appetite by claim type, escalation routes, and the management information a board must be able to evidence.	4 weeks
05	**Evidence integrity and fraud response**	Threat assessment and control design for AI-generated claim evidence — the defensive capability most firms do not yet have.	4 weeks
06	**Benefit realisation framework**	The seven measures above, instrumented and baselined before deployment rather than reconstructed afterwards.	3 weeks, parallel
07	**Build, buy or partner evaluation**	Vendor assessment including concentration risk, exit and lock-in, and critical third-party exposure.	4–6 weeks
08	**Twelve-month mobilisation roadmap**	Sequenced plan with decision gates, dependencies and resourcing, no-regrets moves first.	2 weeks

WHERE TO START

Workstreams one to three form a natural first step of six to eight weeks and can be run without committing to any technology decision. They answer three questions a board will ask before it funds anything: what have we already got, what could we safely do, and who carries it if it goes wrong.

THIRTEEN

Sources

Every figure in this document traces to one of the following.

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Neil Catton is an independent technology strategist with more than thirty-eight years of technology leadership across more than twenty UK sectors, having begun as a computer operator at British Nuclear Fuels and progressed through Oracle engineering and systems architecture into technology leadership.

He has held CTO and Director-level roles at BT, Wipro, Fujitsu, Sopra Steria and Capita. At BT he was one of three architecture directors over a practice of more than a hundred architects, and led a £1.5bn transformation programme. He was previously CISO at Capita.

His insurance experience includes motor insurance data platforms and insurer accident management and telematics work at Wipro, claims transformation in the London Market, insurance consulting at Capita, and a current advisory role as nominated COO of an insurance startup in the long-term savings and pension-adjacent product space.

He now works across a fractional portfolio — fractional CTO and CIO, non-executive and board advisory, AI board briefings and readiness reviews, technology due diligence, data strategy, and interim and programme recovery.

He is the author of four books — the trilogy *The Next Evolution*, *The Cognitive Crucible* and *The Shadow System*, and the standalone *Working as Designed: Why systems that work still fail the people inside them* — and writes at *The Next Evolution*. The writing informs the advisory work, and the advisory work informs the writing.

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How this briefing was produced

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- **Not advice.** This document is general market commentary. It is not legal, regulatory, financial or professional advice and must not be relied on as such. Obtain qualified advice before acting on anything in it.
- **Position and date.** The position is stated as at 2 August 2026. Regulatory positions referenced here changed within the fortnight before publication and may have moved again since.
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