

A scenic view of a town, likely Hereford, with a prominent clock tower. The town is surrounded by lush green trees and rolling hills in the background. The sky is clear and blue. The text is overlaid on the top left of the image.

# Herefordshire Community Activity Strategy 2026-2028

Connecting people to live the lives they want to lead through choice,  
independence, community and flexibility.

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## Summary

This strategy focuses on individuals with care and support needs, this includes adults with learning disabilities, autism, mental health conditions, physical disabilities, and older adults. Many of these individuals still struggle to take part in everyday community life. They often face barriers such as limited opportunities, inaccessible services, and difficulties with transport or confidence. These challenges can lead to isolation and fewer chances to learn, socialise or take part in activities that matter to them. Without change, people risk missing out on the things that help them stay well, connected and independent.

Herefordshire Council is committed to reducing these barriers and helping individuals live as independently and confidently as possible. We want to support people to stay well, build on their strengths, and be active members of their communities. The Council will work to make sure that flexible, accessible and meaningful opportunities are available to everyone who needs them.

Community activities and day opportunities play an important role in helping people live full and enjoyable lives. They give people the chance to make friends, learn new skills, stay active, try new things, volunteer or even prepare for work. A meaningful day can help with mental and physical health, build confidence, and reduce loneliness. These opportunities support people to be part of their community in ways that matter to them.

This strategy has been shaped by what individuals, carers and providers have told us. Through events, surveys and conversations, people shared what they enjoy, what's

missing, and what would make a real difference in their lives. Their feedback has helped us understand what needs to change and what kind of support people want in the future.

Our vision is for a Herefordshire where individuals with care and support needs have real choice in how they spend their time. We want people to be able to access a wide range of activities in their local communities, at times that suit them, including evenings and weekends. We see a future where support is flexible, personalised and focused on helping people build skills, confidence and social connections as their needs and goals change over time.





Right now, many people rely on building-based services that run mainly on weekdays. While these services are valued, they don't always offer the variety or flexibility people want. Others use Direct Payments, Personal Assistants, Shared Lives or local clubs and groups, but these options are not available everywhere. Needs are becoming more complex, and the current market needs support to grow and offer more choices across the county.

Carers play a vital role in supporting individuals with care and support needs, and they need reliable and flexible opportunities to help them take breaks, manage work, and look after their own wellbeing. Carers have told us that



having a range of accessible activities available at different times of the day and week would make a big difference. This strategy recognises carers' needs and aims to make sure they have the right support too.

This strategy sets out how we will improve community activities across Herefordshire. It will help us create more flexible and varied options, support people to build skills and independence, and introduce new ways of funding that give people more control. Over time, this strategy will help individuals shape their own meaningful day, give carers better support, and create a stronger, more inclusive community for everyone.

In summary, the key aspirations of this new strategy are to:

- Increase peoples access to activities within their local community
- Give people more choice and flexibility
- Enable more evening and weekend opportunities
- Increase peoples access to independence and daily living skills
- Have more people accessing volunteering, education or work
- Allow carers to feel better supported
- Shape a stronger, more diverse local market
- Increased use of Shared Lives Shared Days
- Increased use of ISFs to personalise support

## Why the need for change?

Across the country, local authorities are taking a broadly similar direction in reshaping community activity and support for people with care and support needs, with several clear themes emerging.

Many councils are developing whole-system market plans that expand community-based options and reduce reliance on traditional building-based or inpatient provision. Local authorities are also aligning with national frameworks such as Transforming Care and Building the Right Support, using these to guide commissioning of meaningful community activity, forensic community support, intensive outreach services, and housing-enabled independence. The Local Government Association's service model guidance emphasises community-based activity that maximises choice, reduces admissions, and builds ordinary life opportunities, which many councils adopt in their commissioning strategies.

In addition, CQC's updated "Right Support, Right Care, Right Culture" guidance is shaping local commissioning by reinforcing the need for small-scale, community-integrated support that promotes autonomy, everyday participation, and access to local activities.

Skills for Care's cross-system commissioning framework for autistic people encourages authorities to map local need, work in partnership with VCSE sectors, and commission activity that is person-centred, preventative, and co-produced. This includes commissioning local social groups, skill-building programmes, peer networks, and targeted community activity that aligns with personal goals and supports long-term independence.

Community-based activities play a vital role in supporting healthy ageing by improving social connection, wellbeing and independence

among older people. Evidence from the Social Care Wales shows that participation in community activities reduces loneliness and social isolation—factors strongly linked to poorer physical and mental health—while also promoting physical activity, confidence and lifelong learning.



These activities also act as an important gateway to wider support, helping people to access local services and build networks that enable them to remain independent at home for longer. At a system level, the Centre for Ageing Better highlights that community-based approaches are associated with improved health outcomes, increased social participation and more preventative, integrated models of care. To be effective, these opportunities must be accessible, inclusive and flexible, enabling older people to engage in ways that reflect their individual needs and preference



Overall, local authorities are increasingly moving toward community-rooted, personalised, preventative, and co-produced model, supported by flexible commissioning and strong partnerships with the voluntary and community sector.

ADASS (Association of Directors of Adult Social Services) suggest a series of changes for a more flexible approach that services can adopt including:

- The ability for people using services to be able to switch between services to maintain their original levels of service and support
- A wider variety of options available to people, so they can move to a more community-based model and become less reliant on building-based services
- More alternative ways of giving unpaid carers a greater say and choice in how they get support in caring
- Good digital access to services for those who don't want to go out during the pandemic
- The opportunity to move from traditional building-based to more personalised and flexible service

We conducted research into other local authorities' community activity offer and models of delivery. Multiple local authorities are using a tiered approach to their model of delivery and the most common language used to identify the different tiers are:

1. Universal, preventative: community networks; drop-ins; information & advice
2. Early intervention, enablement, time-limited programmes; supported access to community



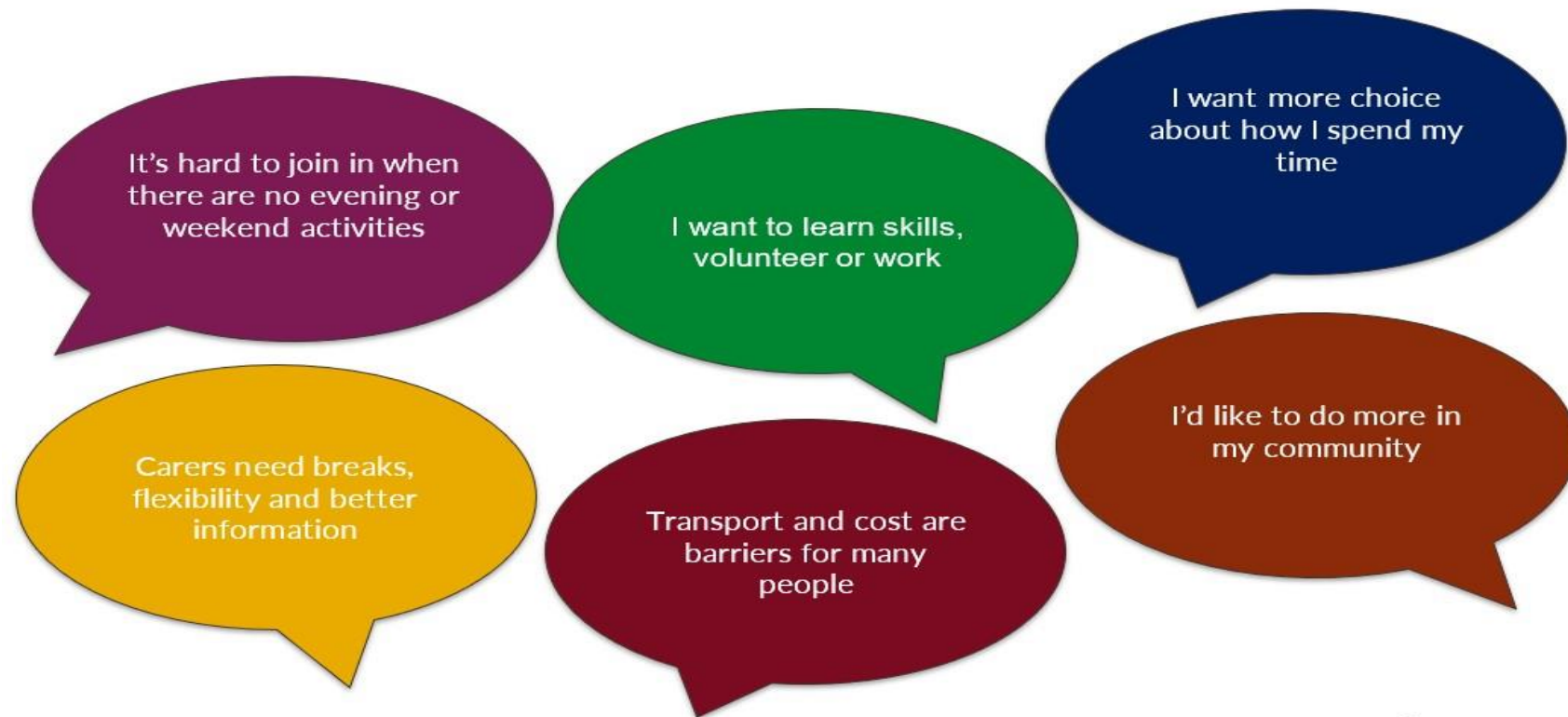
3. Personalised, regular support; mid-level needs; building or community based
4. Specialist, intensive, complex: building-based services; higher/complex needs; intensive/long term

Prevention also supports system sustainability and improves quality of life. Local authority market-shaping, identifies rising demand, increasing complexity, and financial pressures, reinforcing the need for preventative, community-rooted support that delays or avoids the need for intensive social care or specialist placements. Early help builds skills (e.g., communication, daily living, emotional regulation), supports families, strengthens resilience, and reduces behaviours that challenge. Early help and prevention is not only ethically and clinically right, but foundational to reducing inequalities, improving independence, and ensuring people with care and support needs live fulfilling, self-directed lives.

## A review of Community Activities

A comprehensive programme of engagement and evidence review informed the strategic direction and demonstrates strong support for modernisation.

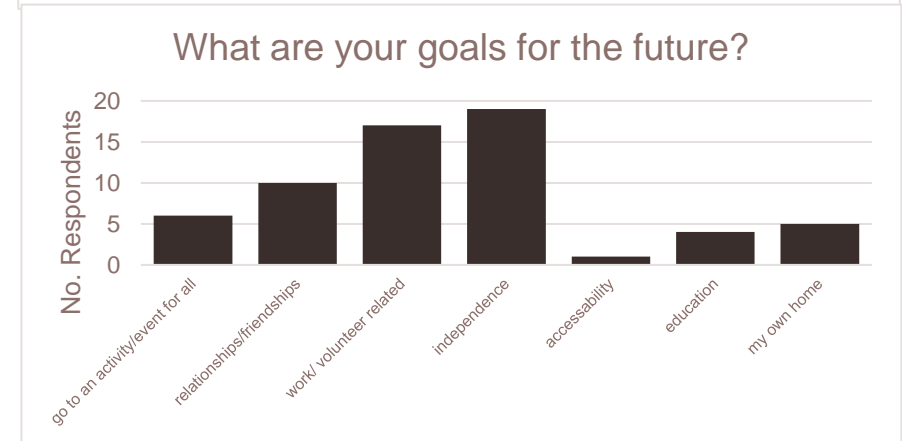
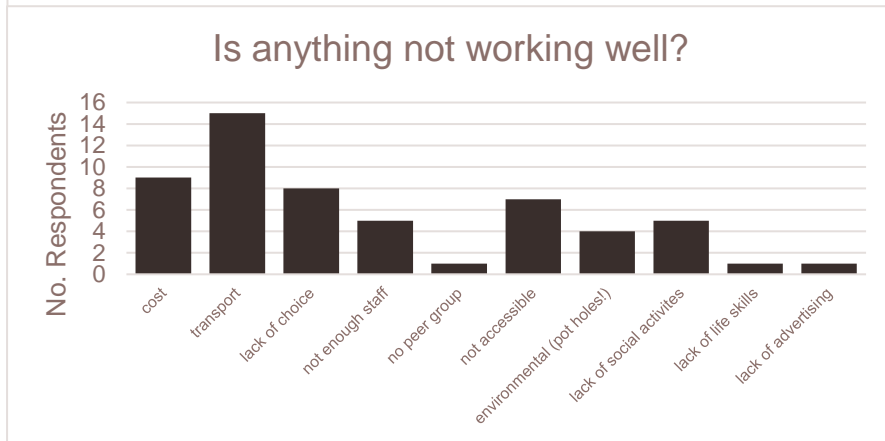
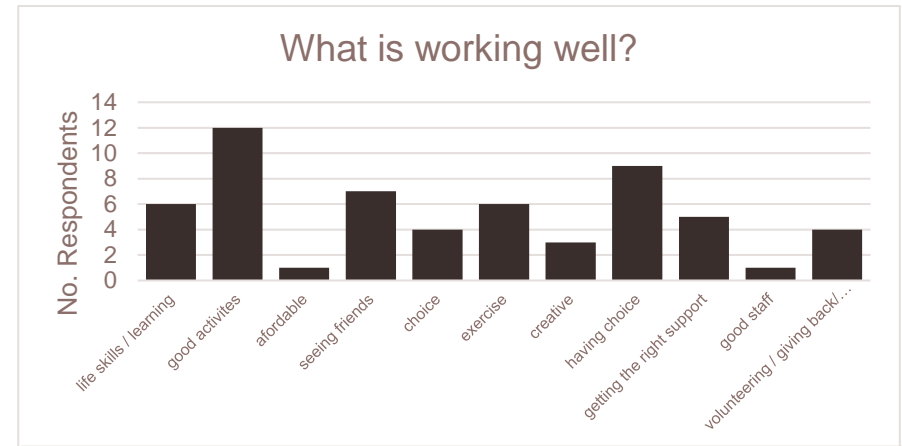
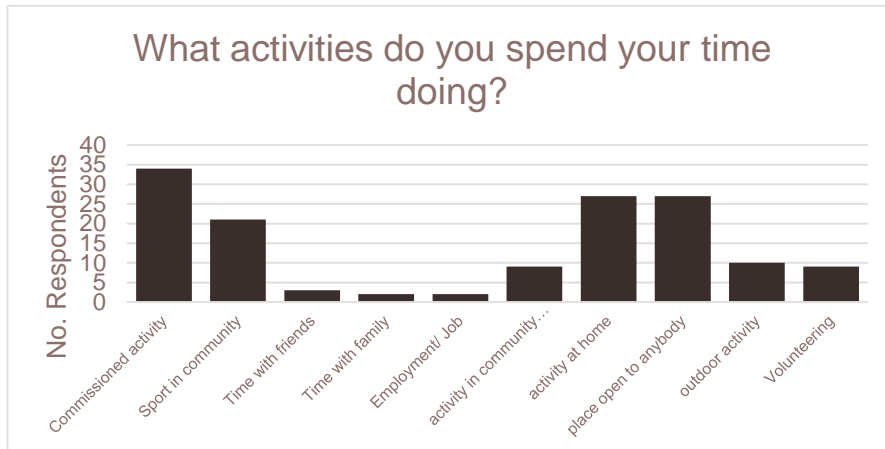
Individuals and carers shared many important messages, including:



## Engagement with people who use services and their carers

### Hear Our Voices Event

In May 2025, 80 individuals with care and support needs were asked about their experiences of the current community activity offer during the Hear Our Voice Event. They told us:



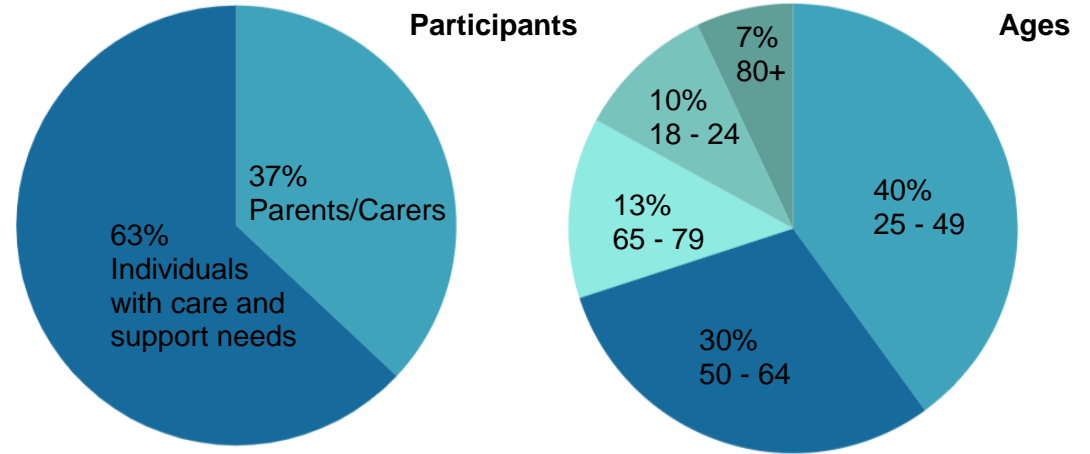
## Online Survey

In January 2026 we released a survey asking individuals with care and support needs, and their parents and carers about how individuals spend their time, what's working well, what isn't working so well, what's important and what they'd like to see in the future.

Top 3 responses for "what does good look like" were:

- Sociable / friendly
- Fulfilling / enjoyable / fun
- Stimulating / enabling

| Barriers           | Percentage of respondents who selected these barriers as impacting them |
|--------------------|---|
| Transport          | 40%   |
| Hours of Operation | 24%   |
| Location           | 20%   |
| Availability       | 17%   |
| Accessibility      | 14%   |
| Cost               | 7%  |



People's top goals for the future were:

- Lifeskills and independence
- Learning / trying new things
- Being active / healthy
- Socialising / relationships
- Maintaining their life
- Employment / training
- Independent living

| What matters most?   | Percentage of respondents who selected these suggestions |
|----------------------|--|
| Friendships          | 87%  |
| Preferred Activities | 87%  |
| Gaining skills       | 80%  |
| Respite              | 37%  |

## Provider engagement

Providers contributed through the Provider Forum and targeted discussions.

They described:

- Increasing complexity and rising operational costs
- Low referral volumes undermining sustainability
- Session-based funding limiting innovation and community-based
- A clear interest in flexible funding mechanisms such as Indiviv

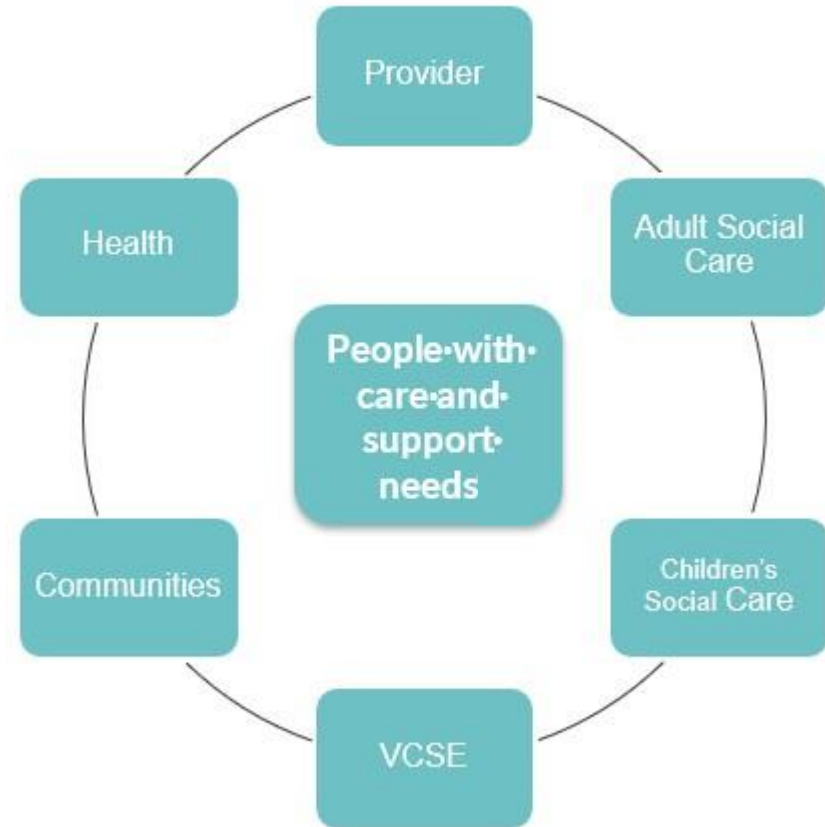
## Professional and system engagement

A multi-agency Steering Group supported the review, including:

- Adult Social Care
- Children's Social Care
- VCSE sector partners
- Providers

They validated data, reviewed findings and shaped themes.

The Learning Disability Partnership Board, including experts by experience and health partners, also reviewed findings and provided assurance.



## Our vision

We want Herefordshire to be a place where:

- Individuals are valued, included, and treated as individuals
- People have real choice and control
- Activities support skills, confidence, wellbeing and independence
- Communities are welcoming and accessible
- Carers feel supported and able to look after their own wellbeing
- Support is available when and where people want it, including evenings and weekends

Most importantly, everyone should be able to say: “I can live a meaningful life and be part of my community.”



## What This Strategy Will Achieve

By 2028, we aim to see:

- More choice and flexibility
- More evening and weekend opportunities
- More people achieving independence and daily living skills
- More people accessing volunteering, education or work
- Carers feeling better supported
- A stronger, more diverse local market
- Increased use of Shared Lives Shared Days
- Increased use of ISFs to personalise support

## What will change?

We are redesigning how community activities work so that individuals can access a wider range of options and have more choice and control over what their support looks like.

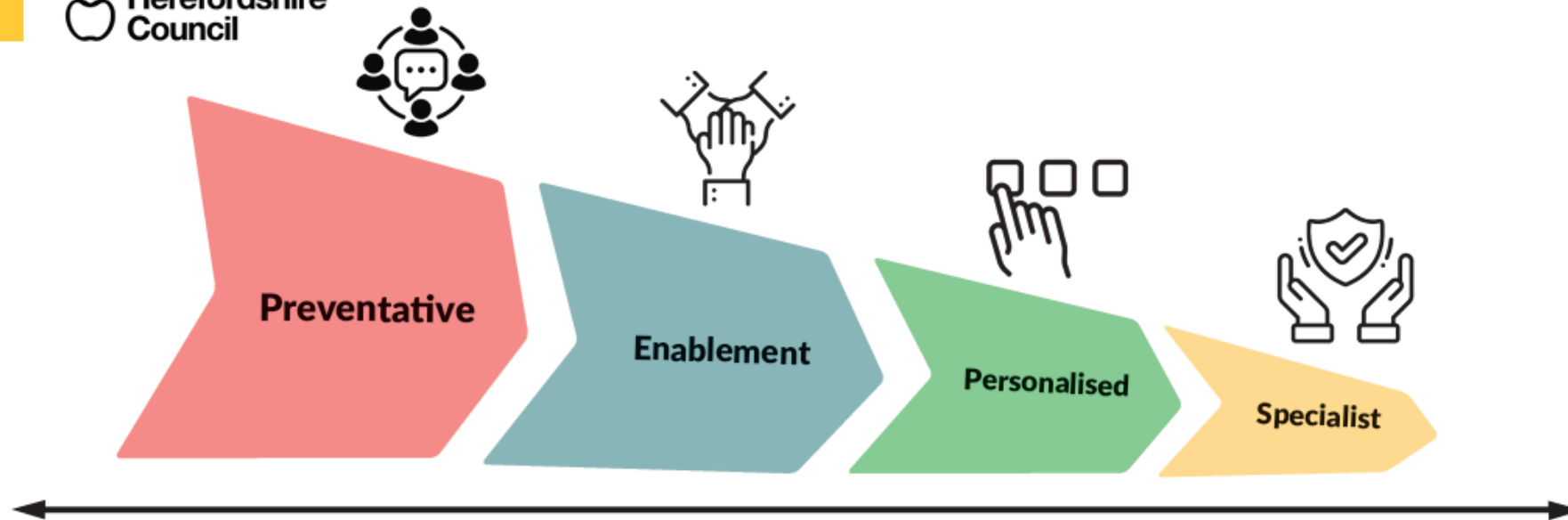
### **A new “four-tier” model**

The strategy introduces four types of support, depending on an individual’s needs and outcomes. It places a strong focus on helping individuals build confidence, develop new skills, and strengthen their independence and wellbeing. We know that people need different levels of support at different times in their lives, and that these needs can change as they get older, experience illness, or grow in independence. For this reason, we are introducing a model with four distinct levels of support, recognising that some individuals will only need short-term, targeted help to achieve their goals, while others may require ongoing or specialist input.

People will mostly be able to take part in activities within their local communities, supported by flexible and personalised options. Those who need more specialist or intensive support may still rely on building-based services to meet their needs safely and effectively. However, our ambition is that everyone, regardless of need, has the opportunity to access community life in ways that feel right for them.

All support will be shaped around the strengths, preferences and aspirations of each person, and delivered in an inclusive way that enables access to ordinary community spaces, leisure opportunities, and employment pathways. Use of Shared Days will also play an important role in offering flexible, personalised support that fits around individual routines and choices.

We also recognise that people’s circumstances can change—for example, someone may want to pursue work, grow older with a learning disability, or their carer’s needs may shift over time. Support will therefore be flexible and able to adapt as life changes, with planning done as early as possible to ensure smooth transitions and continuity of care.



**Purpose:** Enable people to stay connected, active, and independent through ordinary community life, with minimal/no formal support.

**Who it's for:** People who are independent or need only background/light-touch support.

**Typical offer:**

- Information & advice; signposting (wrap around support)
- Community networks & third sector services
- Informal family/friend networks
- Sports, leisure, evening/weekend activities, hobby groups
- Online and community-based drop ins

**Primary outcomes:** Improved life skills, wellbeing and independence; reduced escalation of need.

**Purpose:** Short, outcome focused, time limited support that helps people gain skills, confidence, and connections.

**Who it's for:** People whose independence is at risk and who would benefit from structured support to meet outcomes.

**Typical offer:**

- Time limited enablement programmes (building or community based)
- Skill building (travel training, daily living skills, confidence)

**Primary outcomes:** Gained skills, increased confidence, sustained community connection; safe exit to preventative offer wherever possible.

**Purpose:** Ongoing, flexible, person centred support for people with continuous needs that require regular, structured input (often community based, sometimes building based).

**Who it's for:** People with mid level or fluctuating needs requiring regular support to sustain outcomes, provide carer respite and manage risk.

**Typical offer:**

- Bespoke, strengths based programmes (community connection at the core)
- Regular sessions; outcomes focused reviews
- Access to specialist sessions as needed
- Building based with outreach or community based, depending on need

**Primary outcomes:** Sustained independence, participation, progression.

**Purpose:** High quality, specialist support for people with the complex needs, including intensive, longer term or condition specific support.

**Who it's for:** People with higher/complex needs, including behaviours that challenge, significant health needs, or progressive conditions (e.g., dementia), where safety and outcomes require specialist environments/equipment.

**Typical offer:**

- Specialist, multidisciplinary environments and staffing
- Intensive, longer term packages; risk management
- Therapeutic interventions; clinical liaison; assistive technology
- Building based provision with outreach into the community where safe

**Primary outcomes:** Safety, stability, health outcomes, meaningful engagement, carer respite; enablement elements retained where possible.

## A More Flexible Way to Use Personal Budgets

Currently community activities are accessed through either a commissioned service or a direct payment. We will be looking to introduce Individual Service Funds into this model as an additional option.

Individual Service Funds will become a key part of the new system.

They allow individuals to:

- Use their personal budget more flexibly
- Mix and match activities from different providers
- Change their support without complicated reassessments
- Choose support that fits around their life

This means **the money follows the person**, not the service.

| <b>Feature</b>                         | <b>Commissioned Services</b>   | <b>Direct Payment (DP)</b>   | <b>Individual Service Fund (ISF)</b>   |
|--|--|--|--|
| <b>Who manages the budget?</b>         | <i>The council manages the budget and arranges services directly with providers.</i>                       | <i>Budget is paid directly to the person (or representative) who manages the money themselves.</i>               | <i>Budget is managed by a care provider chosen by the individual; the provider holds and uses the budget on the person's behalf.</i> |
| <b>Level of control for the person</b> | <i>Lower level of direct choice; the person receives support from providers contracted by the council.</i> | <i>Maximum choice and control — the individual decides exactly how funds are spent and arranges all support.</i> | <i>High level of control over how support is delivered, but the provider handles the finances.</i>                                   |
| <b>Administrative responsibility</b>   | <i>Council handles contracts, monitoring, payments, and admin.</i>   | <i>Person must manage finances, keep records, and provide evidence of spending.</i>                              | <i>Provider handles admin, payments, financial reporting, and commissioning of services.</i>   |

| <b>Feature</b>                                | <b>Commissioned Services</b>  | <b>Direct Payment (DP)</b>  | <b>Individual Service Fund (ISF)</b>   |
|---|---|---|--|
| <b>Employment responsibilities</b>            | <i>None — staff are employed by commissioned providers.</i>   | <i>If hiring Personal Assistants, the person becomes an employer (contracts, payroll, insurance).</i>     | <i>Provider employs or subcontracts support staff — no employment duties for the individual.</i> |
| <b>Flexibility of support</b>                 | <i>Less flexible — services follow established models funded by the council.</i>                            | <i>Very flexible — person can buy almost any support that meets their care plan.</i>                      | <i>Highly flexible — providers can reorganise support creatively and quickly.</i>                |
| <b>Suitability</b>                            | <i>Suitable for people who prefer the council to arrange support or need structured, reliable services.</i> | <i>Suitable for people who want full control and can manage (or have help managing) responsibilities.</i> | <i>Good for people who want control but not the burden of managing money or employment.</i>      |
| <b>Reporting requirements</b>                 | <i>Council monitors performance and quality; the individual has no reporting duties.</i>                    | <i>Person must keep receipts, maintain accounts, and provide evidence of spend.</i>                       | <i>Provider reports to the individual and the council on how funds are used.</i>                 |
| <b>Council role</b>                           | <i>Council commissions, manages, and oversees services and contracts.</i>                                   | <i>Council gives money directly to the person; checks spending and reviews care plan.</i>                 | <i>Council transfers funds to ISF provider; monitors outcomes.</i>                               |
| <b>Examples of what funds can be used for</b> | <i>Home care, day services, residential care, reablement, supported living.</i>                             | <i>Hiring PAs, agencies, social activities, equipment, transport (if it meets the care plan).</i>         | <i>Community activities, home-based support, flexible arrangements, specialist services.</i>     |

## Shared Lives - Shared Days

Shared Lives carers open their homes to support individuals as part of everyday family and community life.

In the new strategy, Shared Lives Shared Days will:

- Offer flexible, personalised alternatives
- Support independence and wellbeing
- Provide a family-style environment for social connection
- Fit well within the new ISF-funded model



## Working with the VCSE Sector

We will work closely with voluntary, community and social enterprise (VCSE) organisations to make sure the support they offer fits with the new vision for community activities in Herefordshire. This means:

- Supporting VCSE groups to grow and develop more flexible, local and creative activities.
- Helping organisations offer more choice, including options in the evenings and at weekends.
- Co-producing new ideas with VCSE partners so opportunities reflect what individuals have said they want.
- Improving information-sharing so people know what is available in their communities.
- Strengthening links between VCSE organisations, the Council and local providers so support is better connected.





## Case Study Examples

### Case Study 1: Co-produced Lunch Club (Pooling ISFs)

A group of older people living in the same rural community shared that they felt isolated and wanted more opportunities to socialise locally, particularly around food and conversation.

**Currently:** There is no commissioned offer that could meet this need. Individuals are limited to what is already existing within their communities and would require a Direct Payment to employ a PA to support them to attend depending on the level of support they need.

**New strategy approach:** Through discussions with their provider, they co-produced a solution: a weekly community lunch club held in a local village hall.

Using Individual Service Funds (ISFs), each person contributed a small part of their personal budget. The provider coordinated catering, transport where needed, and support staff.

The lunch club now runs at a time chosen by the group, and attendees can also invite friends or family members. Some participants have taken on volunteering roles such as helping to set up tables or organise activities.

### Case Study 2: Shared Transport Solutions

Several individuals attending community activities identified transport as a key barrier.

**Currently:** The individual would be assessed to determine whether transport support is needed. Where it is identified as necessary, the cost would be allocated specifically to that individual and linked to an agreed journey, day, and time.

**New strategy approach:** Instead of each person using their budget to fund individual support workers for transport, they worked with their provider to develop a shared solution.

Through their ISFs, individuals pooled a small portion of funding to either:

- Book a regular accessible taxi for shared journeys,
- Use a provider-owned vehicle with a driver supporting multiple people at once

This approach reduced costs and freed up more of each person's budget for them to spend on other meaningful activities.

### Case Study 3: Flexible Support for a Working Carer

A carer who works shift patterns found it difficult to commit to fixed day services for the person they support.

**Currently:** If flexible support is required, then the individual requires a direct payment or an agreement with a commissioned provider (not all providers have this as an option). Change to levels of support requires a formal review, creating delays and stress.

**New strategy approach:** The individual's support is managed through an ISF, allowing the provider to flex support week-to-week. When the carer receives their rota, they notify the provider, who adjusts support times accordingly—sometimes arranging evening or weekend activities, or providing in-home support when needed.

### Case Study 4: Peer Support Through Technology (Reducing Paid Support)

Two individuals living in supported living both wanted to increase their independence and reduce reliance on morning care calls.

**Currently:** The only way to reduce support, is by developing skills and independence and reducing the hours of support. There is no mechanism to retain the funds and use it for something else without a review.

**New strategy approach:** With support from their provider, they agreed to trial a peer-support arrangement.

Instead of a daily staff visit, they use simple technology (such as walkie-talkies or messaging devices) to check in on each other every morning. A backup support plan remains in place if needed.

The savings from reducing formal care calls are reallocated through their ISFs to fund activities they value more, such as attending community classes and social groups.

### Case Study 5: Stability and Choice to Maintain Current Support

Not everyone wants or needs to change their support. One individual is happy with their existing care package, attending a service they enjoy and where they have established friendships.

Under the new strategy, there is no requirement to change. The individual continues with their current provision, with reassurance that if their needs or preferences change in the future, they can explore more flexible options such as ISFs or community-based activities.

## What happens next? Co-producing with people and providers

Over the next 24 months we will:

- Develop a dedicated group of individuals who will support us to implement the strategy – the People’s Panel
- Work with the current market, and wider community to offer more flexible options and alternatives to building-based activities, moving out into the community:
  - Continuing our Operational Framework Provider Forum
  - Develop a new Strategic Stakeholder Group
- Work with the Market to roll out ISFs
- Work with partners to refine and define the outcomes focused framework that aligns with the delivery model
- Work with Talk Community to integrate the model so that it aligns with the directory

This will be done gradually and carefully, with choice and stability at the centre.

### **Our Commitment**

We are committed to:

- Working in partnership
- Listening to lived experience
- Ensuring individuals remain at the heart of the system
- Reducing inequalities
- Building supportive, inclusive communities



**Together, we can create a Herefordshire where everyone is supported to live a meaningful, connected and fulfilling life.**