

Independents *for* Herefordshire

Care in Your Home Partnership: Political Group Consultation Response



Response to the Political Group Consultation of 15 September 2026, submitted to the Cabinet Member for Adults, Health and Wellbeing

1 • Introduction and Purpose

Independents for Herefordshire welcomes the opportunity to comment on the proposed **Care in Your Home Partnership** model ahead of the Cabinet Member for Adults, Health and Wellbeing taking a decision. This response draws on the very high level 5-slide presentation given to councillors on 15 September 2026, and the questions and concerns raised by members during that session. It also draws on published evidence about how other local authorities have commissioned home care under similar models, on lessons from other sectors that contract for outcomes or capability, and on the specific risks we believe need to be addressed before a ten-year, county-wide commitment of this scale is approved.

We note that the presentation slides were the only substantive information provided to councillors ahead of and during the briefing. Several of our members raised concerns about the lateness and thinness of the material available at this stage of the process.

2 • What We Welcome

Before setting out our concerns, we want to record the elements of the proposal our group supports in principle:

- A move away from purely transactional, “time and task” commissioning towards outcomes-focused assessment and support planning, which is consistent with the direction encouraged under the Care Act 2014.
- The commitment that residents with established care packages will not be forced to change provider, and that continuity of care will be protected during transition.
- Formal recognition of the Voluntary and Community Sector (VCS) as a partner in delivering low-level, non-personal support such as shopping, prescriptions and light domestic tasks.
- An explicit locality design intended to balance rural coverage with the commercial viability of provider businesses, rather than leaving rural areas underserved.
- A cap of two localities and 3,000 hours per provider, which should in principle guard against over-concentration of risk in a single organisation.

3 · Concerns Raised by Our Members

Our group's concerns fall into five themes, reflecting the points raised in the consultation session.

3.1 Workforce, Volunteers and Rural Delivery

Cllr Harvey placed on record evidence that the volunteer-rich culture Herefordshire has relied on for many years is already showing signs of strain in her locality. A model that leans on volunteer capacity for the support end of the care spectrum, for up to ten years, needs a credible plan for sustaining that supply – not an assumption that it will simply continue. Furthermore, there is significant evidence across the social care sector that use of volunteers within the sector, in a way that delivers meaningful outcomes, requires a significant amount of funded infrastructure, usually within the local VCSE sector. Is this contracting model making provision for such funded infrastructure?

Cllr Harvey also asked directly whether carers will be paid for travel time between appointments, which she rightly identified as a major cost and workforce issue in dispersed rural areas such as the west of the county. This is not a marginal point: under National Minimum Wage rules, travel time between service users' homes and associated waiting time counts as working time, and paying for contact time only is one of the most common compliance failures identified by HMRC in the domiciliary care sector. In a county as rural as Herefordshire, travel can account for a substantial share of a carer's working day, and the funding model must reflect this explicitly rather than push the cost onto providers or, ultimately, onto understaffed rural rotas.

Cllr Harvey further raised the quality of support for carers themselves, particularly young carers sustaining a parent or sibling, and questioned whether this has been done well to date. We ask that the outcomes framework name unpaid and young carer identification and support as an explicit, measured outcome, not an assumed by-product of the wider model.

3.2 Continuity and Quality of Care

Cllr Harvey asked how the model avoids the distress caused by multiple different people visiting one household for different elements of support, rather than a broad package delivered by a consistent carer. Officers responded that this is not the intention outside of specialist care needs. We ask that this assurance be written into the service specification and monitored as a KPI (for example, number of distinct carers per household per month), rather than left as a verbal commitment made in a briefing. User experience is key to achieving improved CQC ratings and forms an important input to the regulator's assessments.

3.3 Market Resilience and Provider Failure

Cllr Harvey asked what has been learned from the failure of a home care provider in Herefordshire a few years ago, and what mechanisms exist to sense supplier performance and quality problems early, and to intervene if a provider in this new framework were to fail. Cllr Stark asked, in similar terms, whether an eight-provider structure makes the market more robust, or simply concentrates risk into eight large, hard-to-replace organisations, and what the contingency plan is if one fails.

This is a well-evidenced risk. The Care Quality Commission's Market Oversight Scheme exists precisely because a small number of large domiciliary care providers have failed or come close to failing in recent years – most visibly Allied Healthcare in 2018, which put continuity of care for over 13,000 people at risk across dozens of local authorities. Section 48 of the Care Act 2014 places a temporary duty on councils to step in and maintain continuity of care when a regulated provider fails, but that duty is far easier to discharge when there are several mid-sized providers in a market than when a single organisation holds the whole of a locality's home care and D2A enablement contract for up to ten years. We ask officers to set out, in terms councillors can scrutinise, the specific early-warning indicators, financial monitoring arrangements and contingency/step-in plans that will apply to each of the eight locality providers, modelled on CQC Market Oversight practice.

3.4 Contract Length, Flexibility and Value for Money

Cllr Crockett, echoing points made by other members, noted that a contract of up to ten years in a rapidly changing care sector is significant, and that the Council needs to understand the break clauses, review points, re-procurement opportunities and performance-related termination provisions built into the contract before it is signed. Cllr Harvey separately asked how demand growth in each locality has been modelled over the life of the contract.

It is not sufficient to simply rely on the ONS POPPI and PANSI projections. There needs to be considerable local trend analysis and this needs to be reflected in the frequency, wording and robustness of the contract's break clauses so as to avoid either expensive contract variations or the risk that a provider's business becomes unviable if actual demand does not match the growth projections used to design their locality.

We also note an apparent inconsistency in the financial information provided to councillors: the briefing summary quotes an estimated whole-life value of approximately £200 million, while other figures available on the council website flagging future contracting opportunities appears to put the total nearer to £320 million. Before a decision of this scale and duration is taken, members are entitled to a single, reconciled and audited figure for the total financial commitment being proposed.

3.5 Governance, Transparency and Member Oversight

Cllr Hitchiner drew a careful distinction: councillors are not there to do the job of officers, and should not expect to see the live commercial contract. However, he argued that if a draft specification is available to all bidding providers, there is no principled reason why councillors should not be able to see what the providers themselves are being asked to deliver. Cllr Tully supported this view, noting the difficulty of scrutinising the relationship the Council is about to enter into for up to ten years and roughly a quarter of a billion pounds, without sight of what is actually being asked of providers. Cllr Hurcomb suggested that commercial confidentiality is likely to cover parts of the documentation but not necessarily all of it – for example, the tender specification and outcomes framework, as distinct from pricing and negotiation detail.

We support this distinction. It is also relevant to the recommendations before the Cabinet Member, which propose delegating not only implementation but all subsequent operational and contractual

decisions, including approval of every contract award, to the Corporate Director for Community Wellbeing for the full ten-year term. Given the scale, duration and novelty of this model, we believe some form of periodic member-level checkpoint should sit alongside that delegation, rather than a single decision point now followed by ten years without further political oversight.

Finally, we ask that future Political Group Consultation sessions on decisions of this significance be held with adequate time for councillors to absorb material in advance, and that officers participate from a suitable private space, as requested by Cllr Harvey during the session, to minimise background noise nuisance.

4 · Learning from Other Local Authorities

Herefordshire is not the first authority to attempt a shift from transactional to outcomes-based home care commissioning, and the experience of others offers both encouragement and caution.

- Kent County Council moved from a large number of separate, transactional home care contracts to eight outcomes-based contracts held by four providers, reducing the overall contract value while shifting risk and responsibility for outcomes onto providers. The evaluated experience found real benefits, but also significant implementation difficulty in recruiting capable care workers and moving the workforce from hourly pay to a salaried model, with higher costs in the early years of transition – a direct parallel to Herefordshire's plan and a strong argument for a longer, better-resourced transition period and workforce plan.
- The Isle of Wight has worked with the Institute of Public Care to move its domiciliary care commissioning away from “time and task” towards an outcomes-based framework, alongside joint work between the council and provider quality-improvement programmes – evidence that outcomes commissioning works best when paired with active provider development, not simply written into a contract and left to run.
- Swindon Borough Council's outcomes-based commissioning of long-term care, built on Mark Friedman's results-based accountability method, links performance measures directly to population-level outcomes for a lead provider working with a network of delivery partners – a structure closer to Herefordshire's proposed subcontracting/coalition model than a single monolithic provider per area.
- Wiltshire's “Help to Live at Home” service is a widely cited example of outcomes-based domiciliary care with payment linked to rehabilitation results, and has been credited with reducing the number of people who need to move into long-term residential care. However, the service model relies on significant changes to their ‘front door’ to successfully reduce the number of people that arrive at the point of being assessed and starting to draw upon state-funded care services. Without similar action, it's difficult to have confidence that the Herefordshire proposed model will be capable of balancing improved outcomes with greater efficiency in the use of local government budgets.

- The Local Government Association's national review of adult social care reform found that current, short-term, activity-based commissioning contributes to market instability, and that councils want longer-term partnerships with providers and stronger outcomes focus – supporting the direction of travel, while also calling for stronger market oversight of large, hard-to-replace providers, which is directly relevant to the eight-locality model.

The consistent lesson from these examples is that outcomes-based, locality or lead-provider models can work, but only where councils invest heavily in provider development, workforce transition support and outcomes measurement infrastructure from day one, and where contracts retain mechanisms to adjust as the evidence base develops. We ask that the Council's proposal set out, explicitly, which of these enabling conditions it has planned for. Where is the evidence that outcome-enabled end-to end infrastructure – from point of s.9 assessment of care and care planning, to delivery of service and analysis of measures of success – is being planned for and provisioned for delivery to support a move to this way of working?

of the overall contract value is being provisioned for in-house to

5 · Learning from Other Sectors: Contracting for Capability and Outcomes

Cllr Harvey specifically raised the defence sector's experience of contracting for capability and availability, exploring whether that has lessons for this approach. We think it does, in both directions.

Since the early 2000s, UK defence procurement has developed “contracting for availability” and “contracting for capability” models, in which a contractor is paid for a guaranteed level of availability or capability delivered (for example, aircraft ready for use) rather than for discrete inputs such as parts and labour hours. The published analysis of this model is directly relevant here: it stresses that outcome-based contracts of this kind shift substantial risk onto the contractor, and that if a contract fails, the consequences can be severe – either poor outcomes for the public, or business failure for the contractor, which then becomes the customer's problem again. This is precisely the dynamic Cllr Stark and Cllr Harvey were probing in relation to single-provider localities.

A second, more cautionary strand of the same literature argues that outcome or capability-based contracting only works well where three conditions hold: the requirement can be fully specified in advance, the relationship can genuinely end at the point of delivery, and the function can be recovered if the contract fails. Analysis of defence procurement finds that capability contracting fails all three tests in that sector – requirements evolve, relationships do not cleanly end, and recovery from failure is difficult – which is why defence has moved towards long-term partnering with structured knowledge-transfer and contingency planning, rather than arm's-length, fixed-specification contracts. Home care shares each of these features: need changes as people's health and the local population change over a ten-year horizon; the relationship between a locality and its sole provider does not “end” at any clean delivery point; and recovering from a mid-term provider failure in a rural, single-provider locality would be genuinely difficult. We would expect the Council's own risk assessment to test the proposed model against these same three conditions before final sign-off.

More broadly, the wider public-sector literature on outcomes-based contracting (used in areas from probation to highways maintenance) is consistent in finding that outcomes-based models improve results only when three things are in place: outcomes that can be measured reliably and fairly attributed to the provider; payment mechanisms that do not simply transfer financial risk the provider cannot manage; and active, ongoing contract management rather than a “set and forget” relationship. We ask that the Council confirm each of these three elements is built into the Care in Your Home specification, not simply the strategic ambition to move to outcomes.

6 • Risk Assessment

Drawing together the concerns raised by our members and others, and the evidence set out above, we ask that the following risks are formally assessed, with mitigations agreed, before the Cabinet Member takes a decision:

Risk	Why it matters	Requested mitigation
Single-provider locality failure	One organisation holds all home care and D2A enablement for an entire area for up to 10 years; CQC's Market Oversight Scheme exists because large providers (e.g. Allied Healthcare, 2018) do fail, putting continuity of care for thousands of people at risk.	Independent financial monitoring per locality provider (modelled on CQC Market Oversight), a tested step-in/contingency plan, and a s.48 Care Act continuity-of-care protocol agreed in advance.
Volunteer/VCS capacity	The model assumes VCS and volunteers can reliably deliver low-level support; members report volunteer numbers already falling locally.	A costed VCS capacity and recruitment plan, with a fallback funded option if volunteer supply is insufficient in a given locality.
Rural workforce cost and compliance	Travel time between visits is legally payable working time under NMW rules and can be 20-30% of a rural carer's day; underfunding this risks non-compliance or unfilled rotas.	Explicit, published travel-time funding assumptions per locality, tested against Homecare Association benchmark rates.
Demand/growth mismatch	If actual demand diverges from the growth projections used to design each locality, providers may become financially unviable or unable to meet need.	Published demand modelling and sensitivity analysis per locality, with agreed contract variation and rebalancing mechanisms.
Contract inflexibility over 10 years	A single long fixed term in a fast-changing sector limits the Council's	Defined break clauses, periodic review points, and performance-related

Risk	Why it matters	Requested mitigation
	ability to respond to new evidence, cost pressures or poor performance.	termination provisions built into the contract structure.
Governance and transparency	Full delegation of contract award and all operational/contractual decisions to officers for the life of the contract limits member oversight of a c.£200-320m commitment.	A periodic member-level reporting and decision checkpoint, and member sight of the tender specification and outcomes framework.
Continuity of the personal relationship in care	Multiple different staff visiting one household can cause distress and undermine outcomes-based assessment.	A specified, monitored KPI limiting the number of distinct carers per household, reported at locality level.
Equalities impact	Moving to locality-exclusive contracting and outcomes-based assessment may affect groups differently depending on rurality, protected characteristics or existing care arrangements.	A published Equalities Impact Assessment covering the transition and the ongoing outcomes model.

7 • Our Recommendations

Independents for Herefordshire asks that, before the Cabinet Member for Adults, Health and Wellbeing takes a decision on the recommendations put forward, the following are addressed:

1. Publish the demand modelling, growth assumptions and financial envelope for each of the eight localities, including sensitivity analysis on volunteer/VCS capacity.
2. Confirm the funding and compliance approach to travel-time payment for carers, particularly in dispersed rural localities, and set it as a monitored contract requirement.
3. Publish an explicit market-failure contingency plan for each locality provider, drawing on CQC Market Oversight practice and the lessons of the previous local provider failure referred to by members.
4. Build defined break clauses, review points and performance-related termination provisions into the contract structure, rather than a single flat ten-year term.
5. Introduce a periodic member-level reporting and decision checkpoint alongside the officer delegation proposed, given the scale and duration of the commitment.

6. Give councillors sight of the tender specification and outcomes framework, distinct from commercially sensitive pricing and negotiation material.
7. Name unpaid and young carer identification and support as an explicit, measured outcome within the outcomes framework.
8. Reconcile the whole-life contract value quoted to members (figures of both approximately £200m and £320m have been cited) into a single audited figure.
9. Publish an Equalities Impact Assessment covering the shift to locality-exclusive, outcomes-based contracting.
10. Set out how lessons from Kent, Isle of Wight, Wiltshire and Swindon's outcomes-based commissioning – particularly on workforce transition and measurement infrastructure – have been built into the specification, ahead of procurement.
11. Set out assurances that an end-to-end practice model of adult social care - particularly for assessment, care planning and review – will be in place to support the ongoing delivery of an outcome-based contracting model. The risk being that if social workers still use a service-driven base for assessment, providers will then carry the burden of translating this into their approach to service delivery.

8 • Conclusion

Independents for Herefordshire supports the ambition behind the Care in Your Home Partnership – stronger, more stable providers, a genuine outcomes focus, and a real role for the voluntary and community sector. Our concern is not with the direction, but with the evidence, safeguards and oversight that should sit around a commitment of this length and value before it is signed. We ask that the points above are addressed and reported back to councillors ahead of any final decision.

Cllr Liz Harvey

For and on behalf of Independents for Herefordshire
19 September 2026

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