Homecare Association

Homecare: commissioning is the key to quality, fair work and better outcomes

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Summary

Commissioning is the mechanism that turns public funding into care, and it shapes everything that follows: the quality and continuity of care experienced by people; the balance of preventative and reactive care and support; whether people have meaningful choice and control; the employment conditions of careworkers; whether providers can meet immigration and employment requirements; the ability and incentives for providers to innovate and adopt technology solutions; the viability of neighbourhood working; and effective regulation of services.

We can increase funding, legislate for better employment rights, negotiate a Fair Pay Agreement, tighten immigration compliance, and strengthen regulation. But these reforms will not achieve their purpose while public bodies continue to buy homecare by the minute, for contact time only, across a hyper-fragmented market that leaves each provider with too little predictable local volume, often at rates below the cost of lawful delivery.

The problem. Too many public contracts combine below-cost fees, fragmented volumes, and payment for exact contact time in arrears, with insufficient attention to quality and compliance. This weakens safety, continuity, workforce security, prevention, and provider investment, even where the service model looks progressive. Because the currency is the contact minute, any change that reduces in-person time - including preventative support and remote monitoring - also reduces income, so the mechanism penalises the very innovation it should encourage.

The destination. Assessed need creates a portable personal entitlement. The person directs it to a chosen provider within a curated, quality-assured local network. The provider receives prospective or regular payment mainly for assessed need and capacity, with delivery flexibility and a modest adjustment for outcomes, experience, and quality - not retrospective payment for contact minutes.

The transition. Neighbourhood commissioning is a practical bridge. Fair prices, sufficient local volume, whole-round or capacity payment, trusted assessment and shared data can create the market and workforce conditions needed for consumer-directed, outcomes-based care.

The immediate ask. Government should convene local government, the NHS, people drawing on care, providers and careworkers, to produce commissioning guides with model approaches and payment clauses, co-design a national framework and contract, and launch council and Integrated Care Board (ICB) demonstrators of the full route.

Reform commissioning now; retire purchase-by-the-minute as the destination is reached.

The pivotal role of commissioning

This paper treats commissioning as system design: the set of decisions that determines what service is purchased, which risks are transferred, how providers organise delivery, the quality of their services, and what employment they can offer.

What the state buys determines what the citizen receives.

If public bodies continue to buy contact minutes from a hyper-fragmented market, often at below-cost rates and without guaranteed volume, additional funding and reforms to pay, employment rights, immigration and regulation will not achieve their purpose.

The central point is simple. Poor care quality and employment challenges in homecare are not only retention, recruitment, training, and compliance problems. They are system design problems. In this paper, we argue for a coherent whole-system approach with four steps, focusing here particularly on commissioning (Figure 1).

Figure 1: Four steps to improving outcomes for people drawing on services and homecare workers

Recruitment and retention

Recruitment and retention in homecare remain difficult in many areas despite an increase in filled posts since the peak of the workforce crisis in 2020/21, after the COVID-19 pandemic (Figure 2).

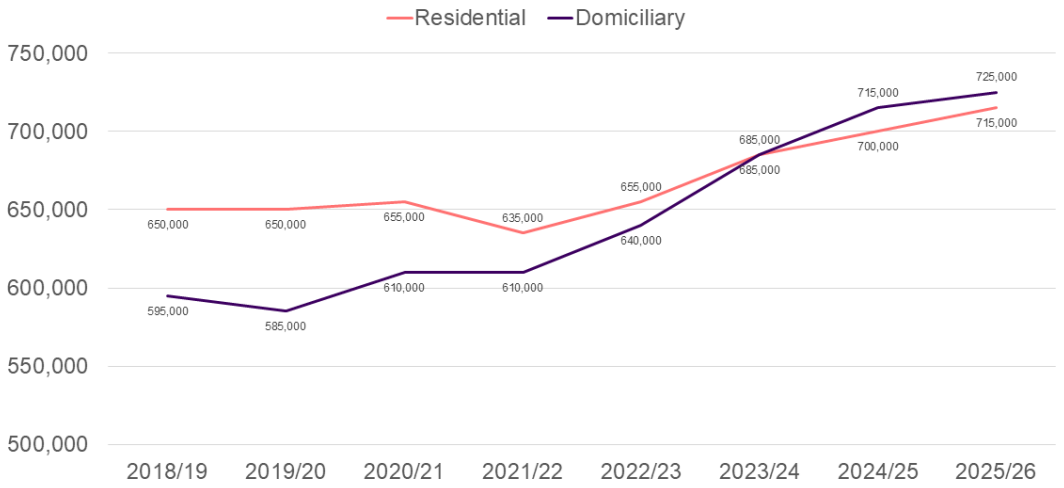


Figure 2: Filled posts in domiciliary and residential care since 2018/19 (Skills for Care, 2026)[1].

International recruits entering the care sector explain growth in workforce numbers since 2021/22. Careworkers became eligible for the Health and Care Worker visa in February 2022, and applications surged. Restrictions followed from 2023. The Government published a White Paper in May 2025, and in July 2025, the Government ended direct overseas recruitment into the care sector altogether. Existing sponsored workers already in the United Kingdom can still extend and switch employers, but only through in-country routes under transitional arrangements due to run until July 2028, subject to review (Figure 3).

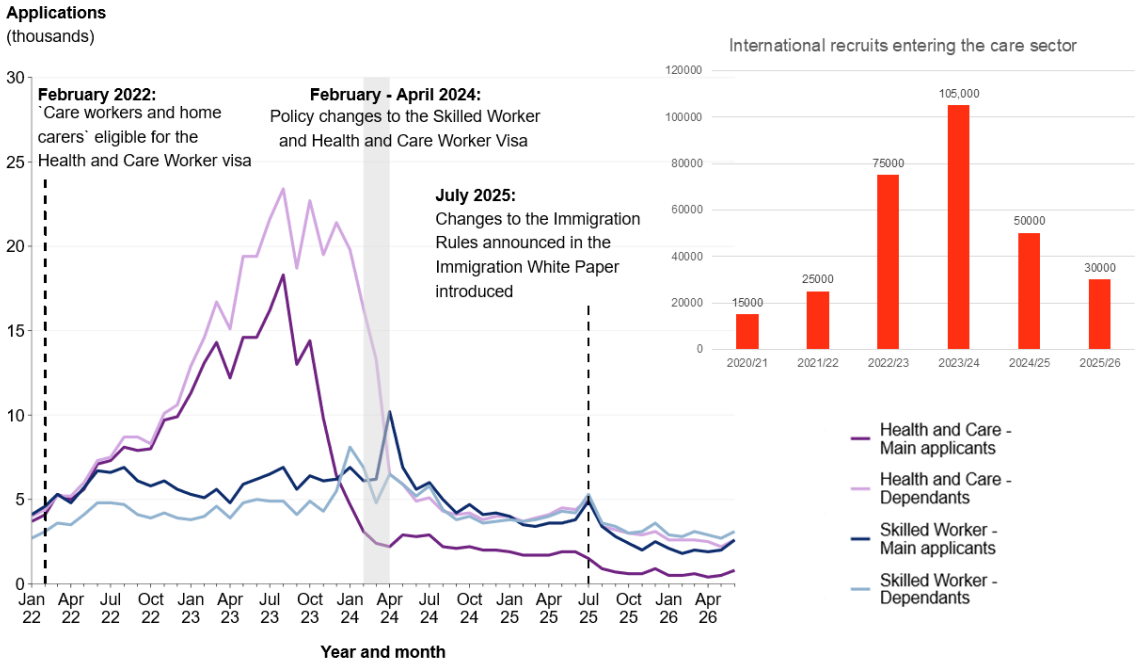


Figure 3: International recruits entering the care sector since 2020/21 (Skills for Care, 2026).

[1] Skills for Care (2026). Size and Structure of the Adult Social Care Sector and Workforce in England.

The inset chart in Figure 3 is the headline: international recruits into care have fallen from about 105,000 in 2023/24 to roughly 30,000 last year. Recruitment has not merely slowed; the overseas front door is closed.

Immigration policy collides with commissioning

Part of the pressure on the Government to stop international recruitment arose from widespread breaches of compliance with sponsorship rules, particularly in homecare. The Homecare Association supports strong action against bogus sponsorship, illegal recruitment fees and deliberate exploitation. Many of the problems are, however, structural.

Government expects sponsors to provide genuine, stable employment, sufficient hours, and salaries that meet immigration requirements.

But homecare providers operate in a market in which the dominant purchasers - councils and NHS bodies - frequently guarantee them no work at all.

A provider may recruit a sponsored careworker based on expected demand, only for a person receiving care to go into hospital, die, move into residential care or have their package transferred at short notice. Commissioners may reduce, move, or withdraw hours at short notice. Frameworks offer no guarantee that replacement work will follow. Regardless, the employer remains responsible for meeting the worker’s sponsorship and employment requirements.

Government expects providers to guarantee workers an income that public commissioners will not guarantee to providers.

That mismatch is structural. No amount of additional enforcement against individual employers can resolve it.

This mismatch does not excuse non-compliance or diminish the protection owed to sponsored workers. Enforcement against exploitation is necessary. It is not sufficient, however, if the state continues to purchase care through insecure, fragmented, and below-cost contracts that make stable hours harder to provide.

A coherent response must pair enforcement with commissioning terms that support lawful employment: sufficient local volume, predictable payment, and fair prices. Otherwise, responsible providers may withdraw from sponsorship, displaced workers may struggle to find regulated employment, and vulnerability may be displaced towards unregulated care in the gig economy.

Since 2020/21, the number of British nationals in the care workforce has fallen by around 130,000, while non-EU numbers rose sharply to fill the gap (Figure 4). For several years, international recruitment was not topping the workforce up - it was holding it up.

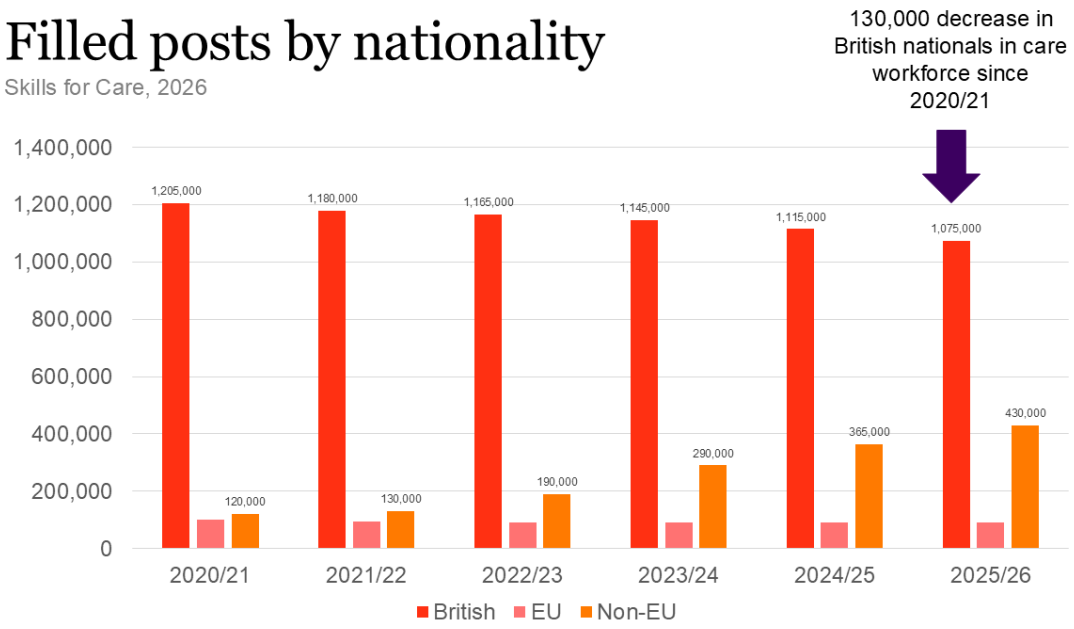


Figure 4: Filled posts by nationality – the decline in British nationals in the care workforce since 2020/21

Skills for Care data show the vacancy rate in homecare in July 2026 was 9.4%, over four times higher than the economy-wide average[2]. Providers compete with retail, hospitality, warehousing, logistics, cleaning, and the NHS. Many competing employers can offer predictable hours, less responsibility, and comparable or higher total earnings.

Skills for Care analysis shows that workers with fewer contracted hours are more likely to leave. It also shows that careworkers on zero-hours contracts have higher turnover than those with over 35 contracted hours. Training is also associated with lower turnover, but investment in training requires stable providers and sufficient fee rates[3].

Therefore, Government must develop coherent immigration, employment, and commissioning policies; otherwise, we cannot meet the rising demand for care at home.

Creating the conditions for good jobs and workforce growth

The Homecare Association supports the objective of ensuring fair pay and improving employment conditions, including through the Fair Pay Agreement.

For many careworkers, fair pay is not only the headline hourly rate but also total income and income security. Like everyone, careworkers need predictable income to pay rent, bills, and food costs. Income insecurity also interacts poorly with Universal Credit and housing support, making some low-paid workers cautious about

[2] Skills for Care (2026). Monthly tracker – recruitment and retention.
[3] Skills for Care (2025). The state of the adult social care sector and workforce in England.

accepting fluctuating hours. Pay that covers client contact time only, leaving travel, waiting and training unpaid, can fall below the minimum wage across a careworker's whole working time, even when the headline rate looks higher. Fair pay therefore depends on paying careworkers for rounds or shifts.

For providers to offer security of work and income to careworkers, they need predictable work and sufficient funding to meet their costs[4]. This depends on the way local authorities and NHS ICBs commission and purchase homecare. The next section therefore tests current commissioning against the four decisions that determine whether this security is possible.

Four commissioning decisions must align

Commissioning is often discussed as though it were a single choice of model. In practice, every contract should be tested against four separate decisions: price, allocation, payment mechanism, and assurance. A serious failure in any one cannot be offset by strength in another, although the four interact: a higher fee rate, for example, reduces the volume of work required for viability. These are diagnostic tests for current contracts; the four steps later in this paper describe the route to reform.

Price. The fee must cover the lawful and efficient cost of the service, including the workforce, travel, supervision, regulation, infrastructure, and a minimum return for reinvestment.

Allocation. Each provider location needs enough reasonably predictable work within a compact geography to build efficient rounds, maintain continuity, and employ stable teams.

Payment mechanism. The contract must pay for planned capacity, an assessed-needs envelope, or agreed outcomes, rather than reconciling income down to isolated contact minutes after the provider has incurred the cost. This is also the unit that most directly penalises prevention and innovation, as explained below.

Assurance. The contract and its management must give commissioners and citizens confidence that care is safe and of good quality and that workers are treated lawfully and fairly. A sound price, allocation, and payment mechanism can each be in place while quality control and employment practices remain poor, so assurance has to be tested in its own right, both before a contract is awarded and throughout its management.

Price - fee must cover the costs of the service required

At the April 2026 National Living Wage of £12.71 per hour, the Homecare Association's calculated Minimum Price for Homecare in England for 2026/27 is

[4] Townson, J.K. (2025). Why Labour's Employment Rights Bill Will Not Improve Employment Conditions in Homecare, Homecare Association

£34.42 per hour[5]. This assumes an efficient provider delivering 1,500 hours a week, no enhancement for evenings, weekends, or bank holidays, and only a modest 4% return for investment (Figure 5). It is a floor for lawful, regulated and sustainable delivery, not an enhanced price for premium care.

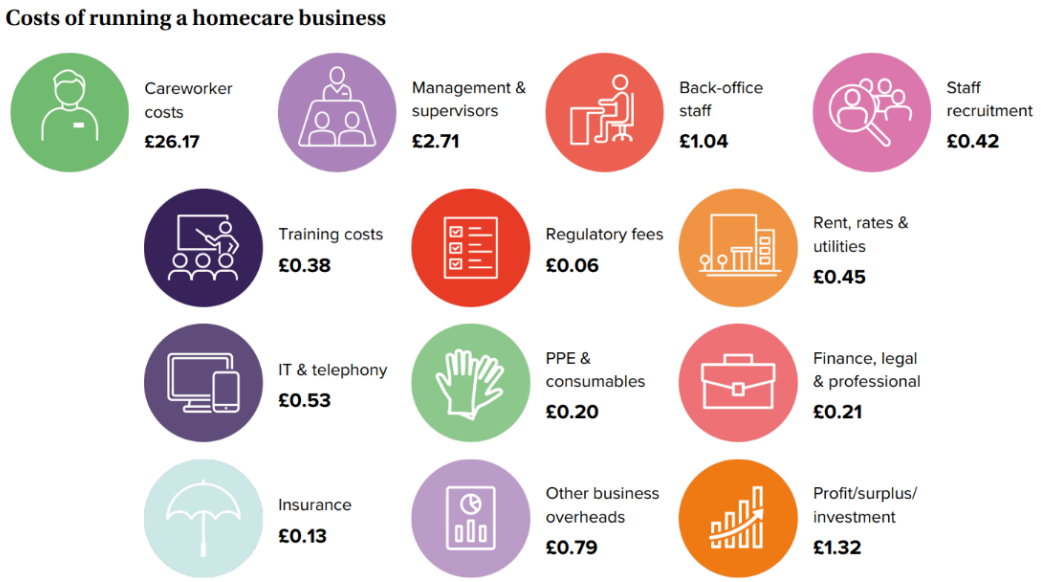


Figure 5: Cost components of the Minimum Price for Homecare 2026/27. Source: Homecare Association.

Of the £34.42, £26.17 is the modelled careworker cost alone. It includes contact time, travel and waiting time, mileage, and statutory employment on-costs. The remaining £8.25 funds the management, scheduling, supervision, training, technology, insurance, quality assurance, and regulatory compliance without which a registered service cannot operate.

Our Homecare Deficit 2025 research shows how far public purchasing has moved from that cost base (Figure 6)[6]. In 2025/26, 29% of councils and Health and Social Care Trusts paid average rates below even the direct cost of employing a careworker at the National Living Wage; only one council paid an average rate at or above the then-current 2025/26 Minimum Price. The estimated UK-wide gap was £3.25 billion (£2.64 billion for England) to pay careworkers at NHS Band 3 and sustain providers.

The result is under-funded travel and waiting time, difficulty guaranteeing workers' hours, inadequate headroom for supervision and training, fragile continuity, shortened care visits, poor quality, and an unstable market that cannot invest in prevention or technology. The rate, volume, payment mechanism, and assurance therefore need to be considered together.

[5] Homecare Association (2025). Minimum Price for Homecare for England, 2026/27.
[6] Homecare Association (2025). The Homecare Deficit 2025.

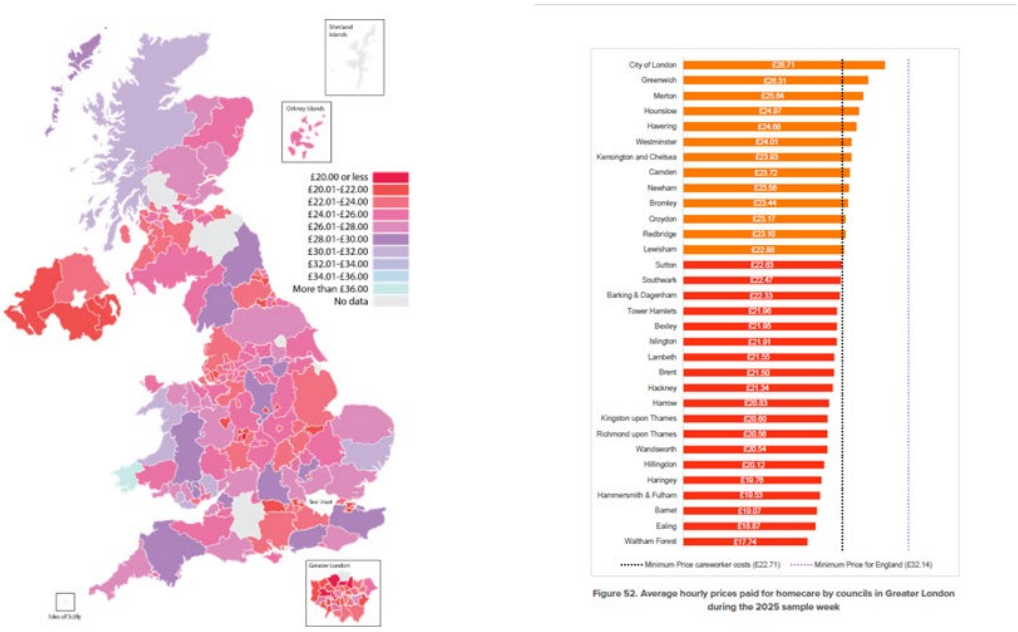


Figure 52. Average hourly prices paid for homecare by councils in Greater London during the 2025 sample week

Figure 6: Variation in average homecare fee rates across the UK (left) and between boroughs within Greater London (right).

Allocation – providers need enough hours per location to create good jobs

The way many councils and ICBs contract with providers and purchase homecare compounds problems of inadequate funding, with direct consequences for workforce stability. Many local authorities and NHS bodies buy care through frameworks, dynamic purchasing systems, spot purchasing, and highly fragmented packages of work (Appendix 1). In some areas, relatively small volumes of work are spread across large numbers of providers. Our Homecare Deficit 2025 research found that 61% of councils and Health and Social Care Trusts purchased no more than 500 hours on average per provider each week. This is a third or less of the 1,500 hours estimated to be needed for efficient operation and financial sustainability at average council and ICB fee rates. Only 1% used block contracts guaranteeing provider income[7].

This matters because providers need sufficient work in a local area to build efficient rotas, minimise travel time, offer guaranteed hours and maintain stable teams. If work is spread too thinly, providers may not have enough predictable volume to offer secure employment. The practical consequences are illustrated in Figure 7, which shows careworkers' rounds among six providers on one day in Bristol. Routes were chaotic and travel time was significantly higher than international benchmarks, which has both cost and environmental implications[8].

[7] Homecare Association (2025). Homecare Deficit 2025.
[8] Health Innovation Network SW (2023). Trial of AI-based optimisation in domiciliary care.

Figure 7: Careworkers' rounds across six providers on one day in Bristol

The careworkers were both poorly utilised and rushed (Figure 8).

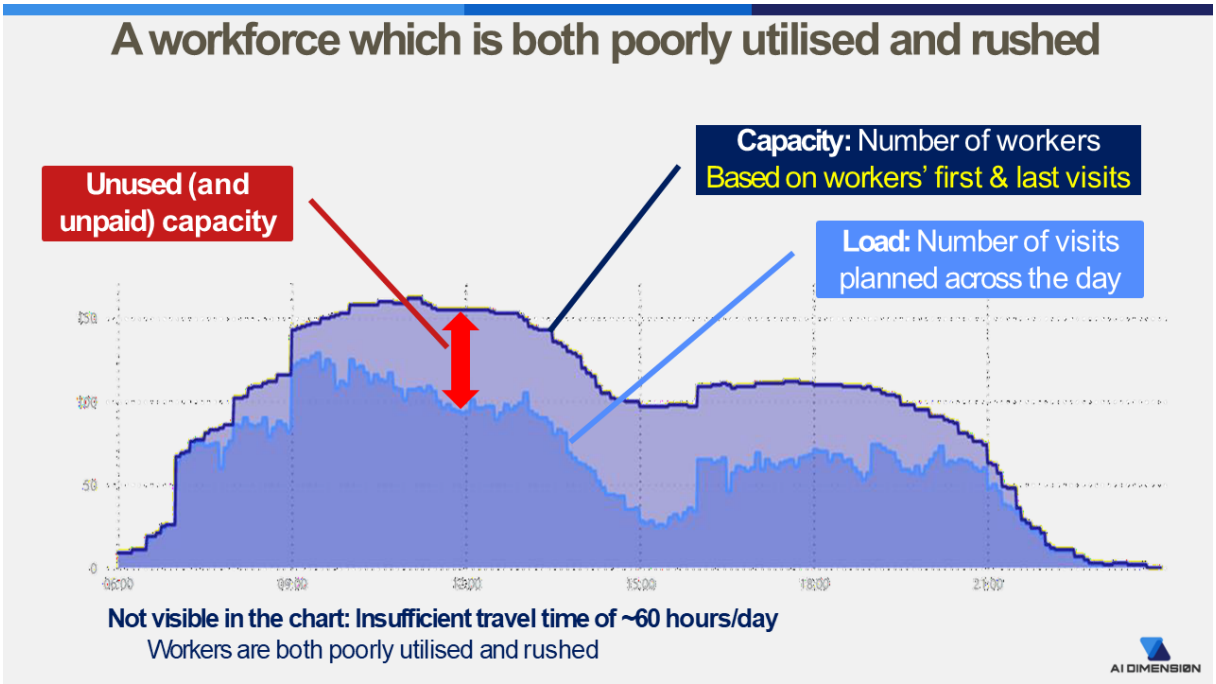


Figure 8: Careworkers have gaps in their rotas and are under-utilised

Many local authorities and ICBs pay providers only for recorded client contact time, with no guaranteed volume. This creates strong pressure for employers to match

labour to variable commissioned demand and contributes to zero-hours or variable-hours arrangements. From a careworker's perspective, the top example in Figure 9 shows an efficient paid round; in the bottom example the worker is out for hours but receives pay for only four calls.

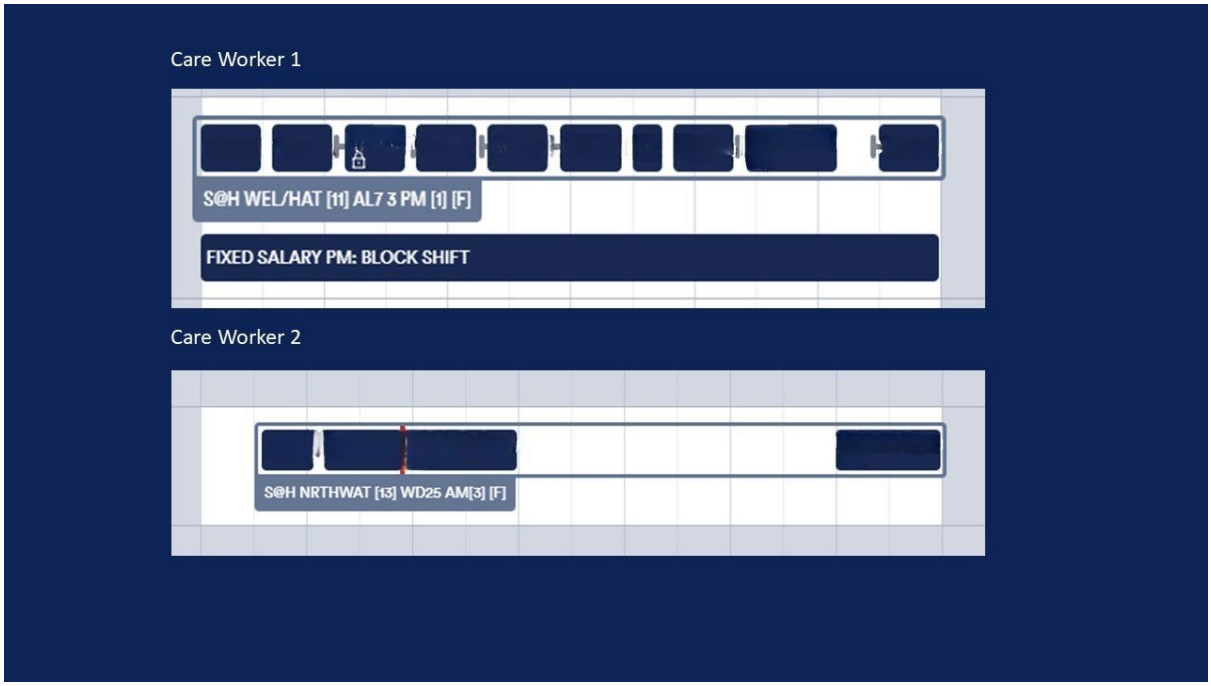


Figure 9: An efficient careworker round (top) and a fragmented round (bottom)

In one modelled zoning scenario, changing commissioning and contracting to give work to fewer providers in different geographic zones, 35% fewer careworkers could deliver the same rounds shown in Figure 7, with a 65% reduction in mileage (Figure 10). This would enable each careworker to have compact rotas with few gaps, creating the conditions to enable shift-based pay or at least payment for a whole round. The purpose is not to reduce the workforce but to release scarce workforce capacity, so that more people can be supported while careworkers gain fuller, better-paid and more secure rounds.

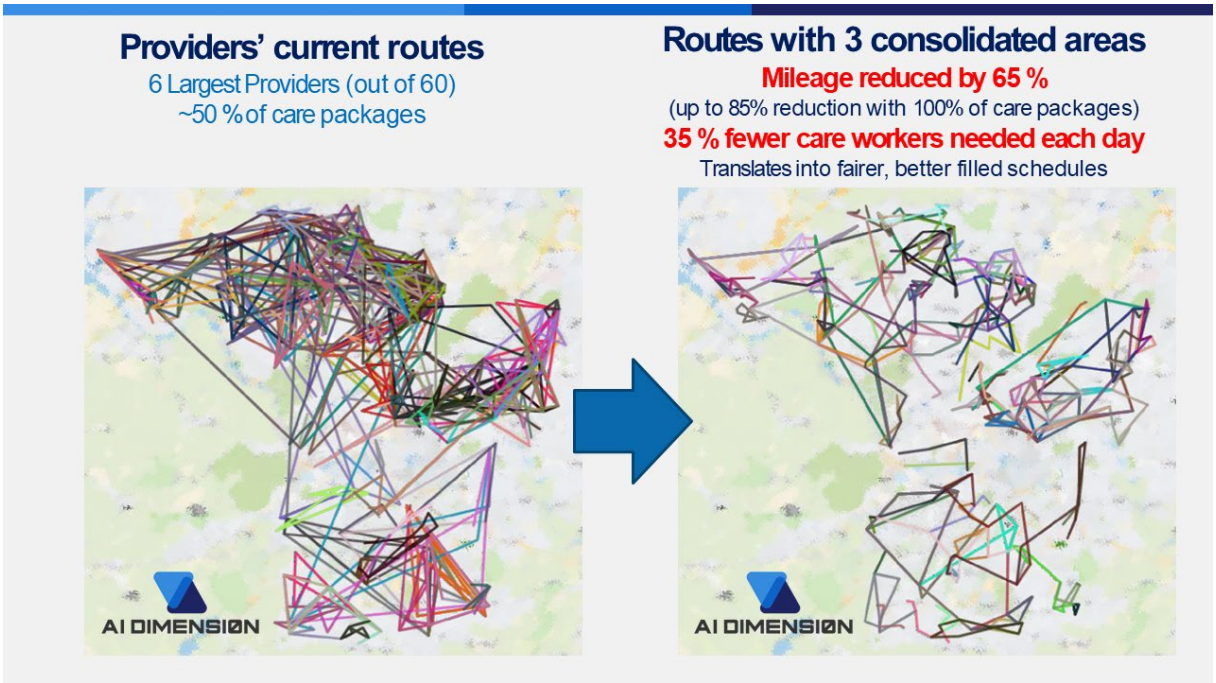


Figure 10: With fewer providers and geographic zoning, the same calls could be delivered by 35% fewer careworkers, with a reduction in mileage of 65%[9].

Hyper-fragmented commissioning can therefore produce insecure income for providers and insecure income for workers. It can also reduce productivity by increasing travel time and making care routes inefficient.

Commissioning practice is therefore a workforce issue, not just a procurement issue.

Payment mechanism – determines income security, continuity of care, and ability to innovate and improve outcomes

The third of these decisions - the payment mechanism - determines not only whether providers can cover their costs, but also what behaviour the contract rewards.

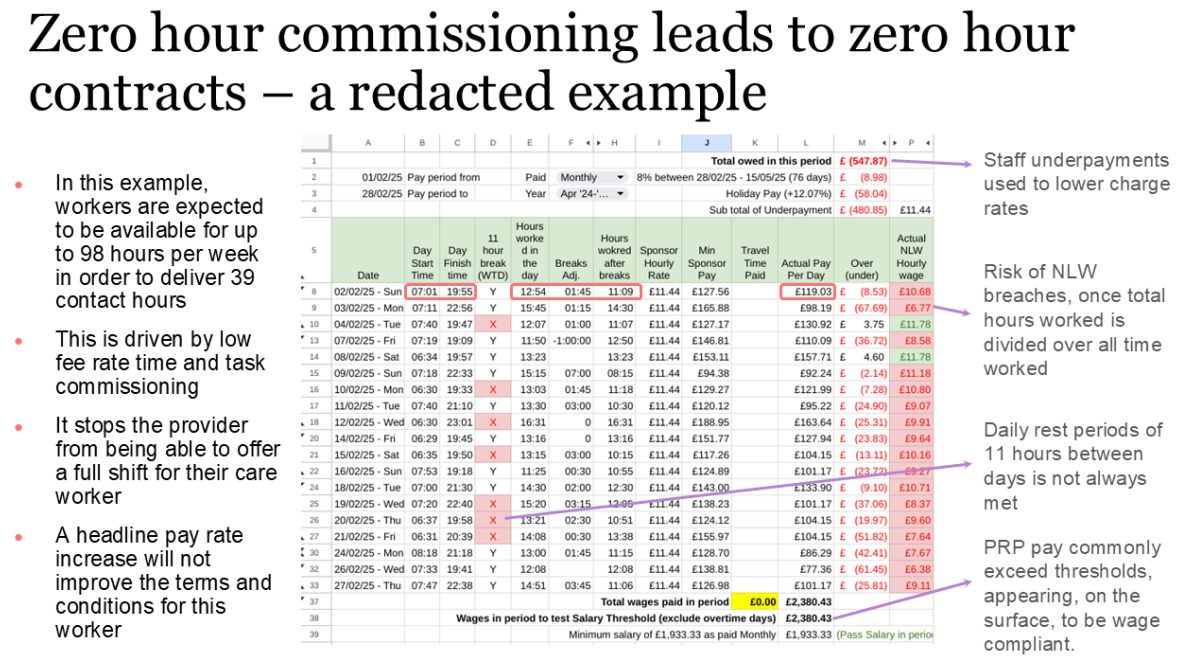
When the currency is the contact minute, a provider's income is a direct function of the time its workers spend in a person's home. Anything that reduces in-person minutes reduces income. This places prevention and innovation in direct conflict with financial survival.

Total income and income security

Hourly pay matters, but careworkers make decisions based on total income and income security. A worker cannot pay rent or household bills with an hourly rate alone. What matters is whether they can rely on sufficient and predictable earnings week after week[10].

[9] Health Innovation Network SW (2023). Trial of AI-based optimisation in domiciliary care.
[10] Homecare Voices (2026). Behind Closed Doors.

There is a further, less visible problem with relying on the headline rate. Many homecare employers pay a headline rate for client contact time only because councils and ICBs pay them for client contact time only. A careworker's day, however, also includes travelling between visits, waiting between calls, training and other duties, all of which count as working time for the National Minimum Wage. When total pay is spread across all this working time, the effective hourly rate can fall below the minimum wage, even though the headline contact rate appears to sit comfortably above it. As illustrated in Figure 11, anonymised records from one provider show careworkers expected to be available for up to 98 hours in a week in order to deliver 39 paid contact hours, the result of low fee rates and time-and-task commissioning that prevent the provider from offering a full, paid shift. A headline pay rate increase, on its own, would not improve the position of a worker in this situation.



										Total owed in this period		£ (547.87)	
	01/02/25	Pay period from			Paid	Monthly	8% between 28/02/25 - 15/05/25 (76 days)					£ (8.98)	
	28/02/25	Pay period to			Year	Apr '24-'...				Holiday Pay (+12.07%)		£ (58.04)	
										Sub total of Underpayment		£ (480.85)	£11.44
Date	Day Start Time	Day Finish time	11 hour break (WTD)	Hours worked in the day	Breaks Adj.	Hours wokred after breaks	Sponsor Hourly Rate	Min Sponsor Pay	Travel Time Paid	Actual Pay Per Day		Over (under)	Actual NLW Hourly wage
02/02/25 - Sun	07:01	19:55	Y	12:54	01:45	11:09	£11.44	£127.56		£119.03	£	(8.53)	£10.68
03/02/25 - Mon	07:11	22:56	Y	15:45	01:15	14:30	£11.44	£165.88		£98.19	£	(67.69)	£6.77
04/02/25 - Tue	07:40	19:47	X	12:07	01:00	11:07	£11.44	£127.17		£130.92	£	3.75	£11.78
07/02/25 - Fri	07:19	19:09	Y	11:50	-1:00:00	12:50	£11.44	£146.81		£110.09	£	(36.72)	£8.58
08/02/25 - Sat	06:34	19:57	Y	13:23		13:23	£11.44	£153.11		£157.71	£	4.60	£11.78
09/02/25 - Sun	07:18	22:33	Y	15:15	07:00	08:15	£11.44	£94.38		£92.24	£	(2.14)	£11.18
10/02/25 - Mon	06:30	19:33	X	13:03	01:45	11:18	£11.44	£129.27		£121.99	£	(7.28)	£10.80
11/02/25 - Tue	07:40	21:10	Y	13:30	03:00	10:30	£11.44	£120.12		£95.22	£	(24.90)	£9.07
12/02/25 - Wed	06:30	23:01	X	16:31	0	16:31	£11.44	£188.95		£163.64	£	(25.31)	£9.91
14/02/25 - Fri	06:29	19:45	Y	13:16	0	13:16	£11.44	£151.77		£127.94	£	(23.83)	£9.64
15/02/25 - Sat	06:35	19:50	X	13:15	03:00	10:15	£11.44	£117.26		£104.15	£	(13.11)	£10.16
16/02/25 - Sun	07:53	19:18	Y	11:25	00:30	10:55	£11.44	£124.89		£101.17	£	(23.72)	£9.27
18/02/25 - Tue	07:00	21:30	Y	14:30	02:00	12:30	£11.44	£143.00		£133.90	£	(9.10)	£10.71
19/02/25 - Wed	07:20	22:40	X	15:20	03:15	12:05	£11.44	£138.23		£101.17	£	(37.06)	£8.37
20/02/25 - Thu	06:37	19:58	X	13:21	02:30	10:51	£11.44	£124.12		£104.15	£	(19.97)	£9.60
21/02/25 - Fri	06:31	20:39	X	14:08	00:30	13:38	£11.44	£155.97		£104.15	£	(51.82)	£7.64
24/02/25 - Mon	08:18	21:18	Y	13:00	01:45	11:15	£11.44	£128.70		£86.29	£	(42.41)	£7.67
26/02/25 - Wed	07:33	19:41	Y	12:08		12:08	£11.44	£138.81		£77.36	£	(61.45)	£6.38
27/02/25 - Thu	07:47	22:38	Y	14:51	03:45	11:06	£11.44	£126.98		£101.17	£	(25.81)	£9.11
						Total wages paid in period			£0.00	£2,380.43			
						Wages in period to test Salary Threshold (exclude overtime days)				£2,380.43			
						Minimum salary of £1,933.33 as paid Monthly				£1,933.33		(Pass Salary in perio	

Figure 11: Payroll records showing why a headline contact-time rate is not an accurate guide to pay across all working time

In homecare, income can fluctuate for reasons outside the worker's control[11]. People receiving support may be admitted to hospital, die, move into residential care, or have packages reduced. Colleagues can go off sick and need their rounds covered. Commissioners may reallocate packages between providers without notice. Providers may gain or lose private-pay clients at short notice. This can affect rotas and income.

[11] Homecare Association (2025). Voices of Homecare.

For workers on low incomes, fluctuating earnings can also interact poorly with Universal Credit, housing support, Carer's Allowance, passported benefits such as free NHS prescriptions and free school meals, and other thresholds. The precise effect depends on household circumstances and benefit rules, but delays and cliff edges can make unpredictable hours feel risky. Workforce policy should therefore consider total earnings, predictability, travel time and benefit interactions as well as the headline rate.

Rewarding prevention and innovation

A provider that introduces technology to monitor a person's health and wellbeing remotely, that supports someone to regain independence, or that resolves a concern with a telephone call rather than a visit, reduces the very minutes on which its income depends. Under time-and-task commissioning, there is a risk that the more effective the support, the lower the payment. Doing the right thing for the person is financially penalised.

This is the opposite of the incentive the system needs. Reablement, assistive technology, remote monitoring, and similar preventative approaches can maintain independence, reduce avoidable hospital admissions, and release capacity for people with the greatest need. A payment mechanism that treats every avoided visit as lost revenue discourages providers from adopting them, even where they would improve outcomes and reduce costs to the wider health and care system.

This compounds the funding problem set out above, but it is not the same problem. Underfunding removes the means to innovate: providers operating on thin margins have little headroom to invest in new technology or ways of working. Payment by the minute then removes the reason to innovate: even a well-funded provider loses income each time it reduces a visit. The first is a question of price; the second is a question of the payment unit itself.

Paying for assessed need, planned capacity, or agreed outcomes - rather than contact minutes - removes this perverse incentive. A provider funded to achieve agreed outcomes keeps the benefit of delivering them more efficiently and can reinvest in the technology and preventative support that make better outcomes possible. This is central to the case for moving from commissioning minutes to commissioning outcomes set out later in this paper.

Ensuring service continuity

Continuity of care matters greatly to people who draw on support, because relationships with familiar careworkers underpin safety, trust, and good outcomes. Fragmented rounds, unpredictable hours, and insecure earnings drive higher staff turnover, which in turn erodes that continuity. The same commissioning decisions that shape income security therefore also determine whether a person sees a consistent team or a constantly changing succession of workers.

Homecare providers operate with limited margins. LaingBuisson analysis reported in 2026 an average EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation) margin of around 8.7% for homecare and supported living providers[12]. Homecare Association letters to ministers have warned that this average masks variation, with many providers struggling to break even.

Low margins matter because policy changes have costs. Increases in the National Living Wage, National Insurance, sick pay, pension contributions, training requirements, regulation, and employment rights all have to be funded. If commissioners do not meet these costs, providers must absorb them, reduce investment, hand back contracts, exit the market or cut corners. None of these outcomes support government objectives.

A sustainable market is not an end in itself. It is the foundation for safe, good-quality, and continuous care, decent work, lawful employment practices, and NHS performance.

Assurance - contracts must secure safe, good-quality care and fair treatment of workers

Price, allocation, and payment determine whether good care and fair employment are financially possible. Assurance determines whether they are actually delivered. A contract can be adequately priced, sensibly allocated, and paid in a way that supports stable teams, yet still permit poor-quality care or exploitative employment if quality and conduct are not assured. Assurance therefore has to be tested in its own right, both before a contract is awarded and throughout its management, rather than assumed.

Good assurance means being explicit about what is measured and how: the safety and quality of care, the experience and outcomes of people drawing on support, and the lawfulness and fairness of employment, including whether workers are paid for their whole working time. It also depends on commissioners being equipped to interpret this information. In practice, commissioning teams do not always have the specialist insight to scrutinise providers' pricing structures and workforce practices, which makes it harder to distinguish sustainable, well-run provision from models that cut corners or rely on exploitative terms. Building this understanding into procurement and contract management is part of assuring quality, not separate from it.

Current procurements and contract changes show why all four decisions matter

Recent council procurements and proposed contract changes show that market shape, fee level, payment mechanism, and quality assurance must be tested

[12] LaingBuisson (2026). Homecare and Supported Living UK Market Report 7th Edition.

separately. A contract can look progressive at the level of service design yet remain unworkable because of the way payment is calculated.

Oldham: a promising structure undermined by its terms

Oldham Council's 2026/27 tender is a clear example (Appendix 2). Its neighbourhood lead-provider model should, in principle, concentrate enough work in compact areas to reduce travel, improve continuity and enable more secure employment. The tender also recognises the value of capacity by commissioning its night service through a block contract.

However, daytime homecare is priced at £25.00 per hour and paid for the exact contact minutes recorded by electronic call monitoring, up to the commissioned maximum, with no guarantee of work. The specification nevertheless expects lead providers to maintain responsive capacity and accept referrals. The Council therefore requires capacity but does not pay for it.

The rate is £9.42 below the 2026/27 Minimum Price, while a 30-minute visit has a modelled cost equivalent to £36.38 per hour because travel, waiting and mileage are spread across less contact time. If a commissioned 30-minute call takes 25 minutes, the provider is paid for 25; if it legitimately takes longer, payment above the commissioned duration is not automatic. The provider carries the downside risk while remaining liable for the workforce and infrastructure required to deliver the service.

This also weakens the integrity of data. Electronic call monitoring should reveal changing needs and support quality assurance. When every recorded minute determines income, accurate records of shorter calls reduce payment even though most costs are unchanged, creating an avoidable tension between candour and financial survival.

The night-time homecare contract price is 16% below the modelled cost of placing two careworkers on every night of the year, an annual shortfall in the order of £24,776, and therefore risks viability and service continuity.

Redcar and Cleveland and Derbyshire: the same structural problem

Redcar and Cleveland now offers exact-minute payment at 2026/27 rates of £23.04 for longer calls and £26.24 for shorter calls. The long-call rate is below the £26.17 direct cost of lawful careworker employment, before any management, supervision or regulatory cost. The Council simultaneously reminds providers of their immigration responsibilities while making commissioned income more variable (Appendix 3).

Derbyshire illustrates a different payment-design risk. Its proposed combined hourly rates incorporate travel as a percentage of contact time, although travel is incurred per visit. The structure therefore funds the shortest visits least generously, even though they cost most to deliver, potentially reducing payment for the brief preventative support on which independence at home depends (Appendix 4).

Taken together, the examples map directly onto one or more of the four tests. Oldham's neighbourhood structure could improve allocation, but daytime price and exact-minute payment undermine it. The night-time homecare contract offers payment for capacity but at an unsustainable, below-cost fee rate. Redcar and Cleveland combines a below-cost fee with exact-minute payment. Derbyshire's combined rate risks underfunding the shortest visits because a per-visit cost is allocated by contact time, thereby disincentivising preventative work. Data should be used to review need and quality, not as a meter that transfers utilisation risk down the chain.

They point to the same conclusion: public funding must move from purchasing contact minutes to funding assessed need, planned capacity and outcomes, with the person directing the support.

From fragmented purchasing to outcomes-based, consumer-directed care

The destination is a system in which public funding follows assessed need and the person's choice, while providers are paid and held to account for the capacity and outcomes they are responsible for delivering.

Minute-based, below-cost and fragmented commissioning is a major structural driver of poor continuity, poor quality, limited consumer choice, insecure work, compliance risk and weak incentives for prevention and innovation.

This requires a shift from public commissioner-directed purchase of contact minutes to consumer-directed funding of assessed need, with payment for planned capacity and a bounded link to outcomes.

Achieving this shift requires time and a transition plan.

We propose neighbourhood commissioning as a transition mechanism, not the final destination. It can first make local delivery viable and build the assessment, data, workforce, and assurance capabilities required for funding to follow the person and for providers to be accountable for outcomes rather than minutes (Figure 12).

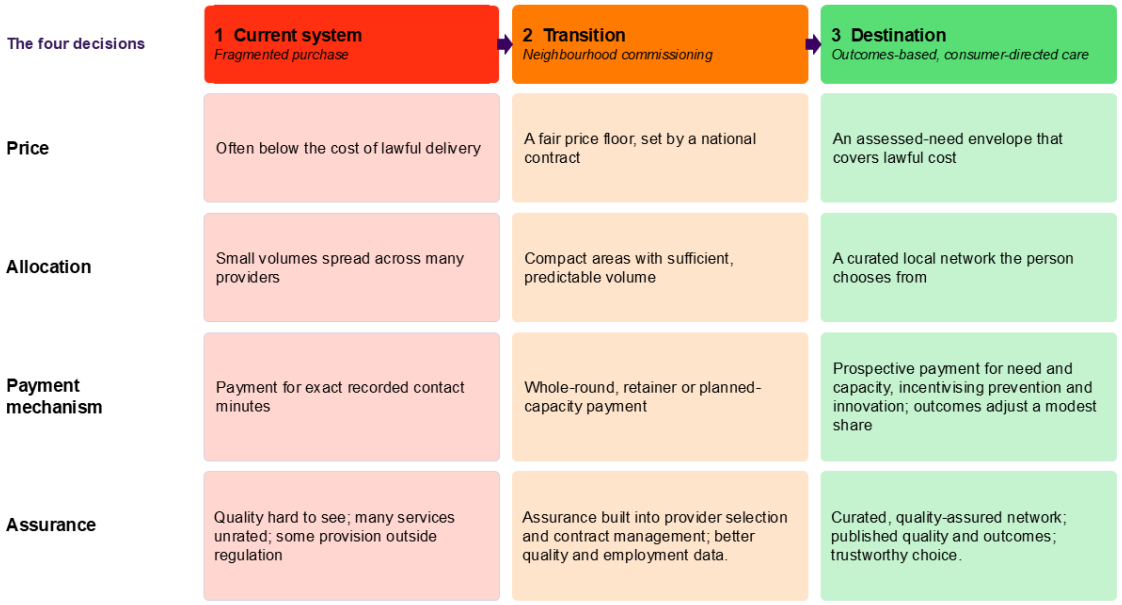


Figure 12: Transition model: neighbourhood commissioning creates the conditions for outcomes-based, consumer-directed care.

How the destination would work

Need sets the budget. The person directs it. Outcomes influence payment. The provider has flexibility over delivery (Figure 13**).**

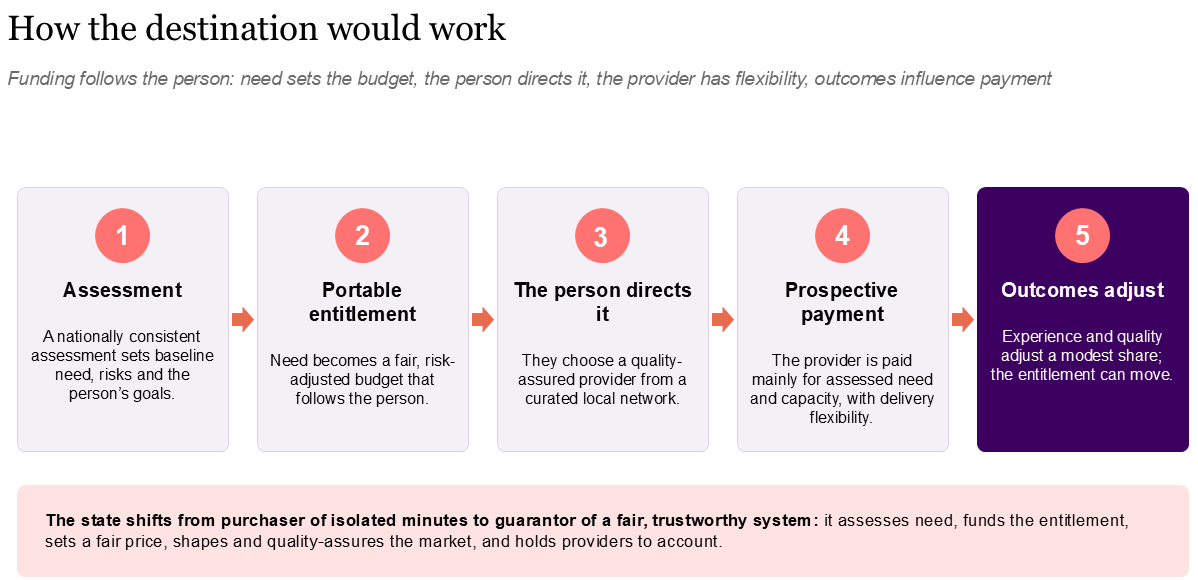


Figure 13: The destination – an end-to-end architecture linking assessment, funding, choice, delivery, and outcomes

1. **Assessment of need and individual goals and outcomes.** A nationally consistent, strengths-based assessment establishes baseline need, functional ability, risks, unpaid-carer circumstances and the outcomes the person wants. The person and those important to them co-produce goals that are specific enough to guide support but broad enough to reflect a life, with proportionate clinical input where needed.

2. **Portable entitlement.** The assessment translates needs and goals into a fair, risk-adjusted, portable funding entitlement. For ongoing support and care, assessment generates a transparent monthly, quarterly or annual personal budget. For reablement or another defined intervention, it may generate a time-limited episode funding envelope. Both are adjusted for complexity, geography, and legitimate cost drivers, with a price base that covers lawful delivery. Australia provides one illustration of assessment-linked national funding classifications[13], and the US Medicare system another[14]. England would need its own model but could learn lessons from other countries. The entitlement need not be paid to the person as cash: it can be administered on their behalf, as the Services Australia payment infrastructure illustrates[15]. Current personal budgets and direct payments already provide elements of choice and control; what would be new is how the funding is derived and paid. The publicly funded envelope would be calculated transparently from assessed eligible need and the lawful cost of delivery, would be portable between eligible providers, and would be paid prospectively rather than realised through minute-based purchasing. The entitlement would be calculated after applying the relevant eligibility and charging rules, so this reform concerns how the publicly funded portion is determined, directed and paid, not the introduction of universal, non-means-tested care.

3. **The person directs where the funding goes.** The portable funding entitlement follows the person, who can choose from a curated local network of quality-assured providers, use a personal budget where appropriate, or ask the council to help them find support. The person agrees the care and support plan with the provider, who is free to deploy the team, visit pattern, technology and community connections that best achieve the goals. The source of funding should not determine the person's ability to choose. This is consumer direction, not an expectation that every person becomes a micro-employer, though they could if they wished. Independent information on quality, continuity, workforce stability, and outcomes must make the choice usable. The network should preserve preference and contestability while concentrating enough local volume to sustain stable employment and maximise efficiency. The entitlement follows the person and moves if they change provider.

[13] Townson, J.K. (2025). Homecare reform in Australia.
[14] Townson, J.K. (2026). How the United States funds and delivers care at home.
[15] My Aged Care. Manage your Support at Home budget. Services Australia. Support at Home program for aged care providers.

4. **The provider is paid prospectively to meet assessed need.** The chosen provider receives dependable payment mainly for the assessed-needs envelope and the capacity required to meet it, rather than retrospective payment for contact minutes. The provider and the person agree on how to use the funding. The provider can vary visit length, timing, staffing, technology, and community support within clear safeguards to meet needs. Minimum service and safeguarding requirements remain; assessment, review, experience measures and audit protect against under-service.

5. **Outcomes influence a limited part of payment.** A small national outcome set combines personal goal attainment with functional ability, wellbeing, safety, continuity, carer experience, and avoidable use of urgent or institutional care. Case-mix adjustment and balancing measures, including missed care, complaints, safeguarding, and hospital use, are needed to deter selection and gaming. At review, change is measured from the person's baseline against agreed goals, experience, and quality. A modest proportion of payment may be adjusted, but risk adjustment, shadow testing, balancing measures, and appeal arrangements should protect against gaming, instability, and factors outside the provider's control. Providers submit a common dataset at assessment, review, and closure, and people drawing on services provide structured feedback on their experience. Commissioners and regulators audit assessment and care-plan quality, publish intelligible information, and use the data for improvement as well as accountability. People drawing on care, providers, councils and NHS partners govern the model jointly and review unintended consequences.

The state therefore changes from purchaser of isolated minutes to guarantor of a fair and trustworthy system: it assesses need, funds entitlement, establishes a fair price, shapes and quality-assures the market, publishes intelligible information, and holds providers to account.

International experience reinforces that this stewardship role does not disappear under consumer direction. Australia already operates assessment-led, person-directed public funding for aged care at scale, which shows the destination is not theoretical. Its experience also carries a clear caution: individual entitlements do not by themselves create viable supply. Australian government officials described active stewardship of thin markets, particularly in rural and remote areas, using loadings and additional funding, capital and workforce support, and commissioned or limited-provider models where normal competition cannot sustain provision[16]. Consumer choice, in other words, operates within a market that government continues actively to shape.

[16] Australian Government Department of Health, Disability and Ageing (2026). Support at Home Thin Markets Grants.

What US Medicare's OASIS architecture demonstrates

US Medicare home health is a useful proof of concept for parts of this approach. The transferable lesson is the architecture, not the US eligibility rules. Medicare home health is clinically led, episodic and closer to NHS community health services and reablement than to ongoing adult social care[17].

A registered nurse or therapist completes the standard electronic Outcome and Assessment Information Set (OASIS), observing the person across functional, clinical, and psychosocial domains[18]. The assessment records goals, informs the care plan, and contributes to the funding calculation.

Payment is made through case-mix-adjusted 30-day periods rather than contact minutes. The home health provider can deploy nursing, therapy, and home health aides as the care plan requires. OASIS is repeated at specified review and discharge points so change can be compared with the person's baseline and expected outcome; claims measures and mandatory patient experience surveys add further evidence.

Under the expanded Home Health Value-Based Purchasing model, a home health agency's Medicare fee-for-service payment can move by up to 5% in either direction according to a composite of outcomes, utilisation and experience. Performance is measured and publicly reported, aligning provider flexibility with accountability.

Though the service model is different and not directly transferable to the UK setting, England can learn from the way standard assessment, needs-based funding, provider discretion, repeated outcome measurement, consumer experience, and public quality information operate together.

Four steps needed to make the transition

The features above describe the destination. The following four steps are the practical route: reshape local markets, establish a fair price, turn funding into secure income, and provide trustworthy quality assurance (Figure 14). These four steps correspond directly to the four commissioning decisions set out above: shaping the market to allocation, a fair price to price, secure income to the payment mechanism, and fair regulation to assurance. Together they underpin the trustworthy choice on which consumer direction depends.

[17] Townson, J.K. (2026). How the United States funds and delivers care at home. Centers for Medicare & Medicaid Services. *Home Health Prospective Payment System*; Centers for Medicare & Medicaid Services. *Expanded Home Health Value-Based Purchasing Model*.
[18] Centers for Medicare and Medicaid Services. OASIS Data Sets.

Figure 14: Four steps to improving outcomes for people drawing on services and homecare workers (repeated from Figure 1).

Step one: shape the market around people and places

Homecare needs to move away from the daily auction of individual packages across large numbers of providers over wide geographies.

This is not an argument for replacing small providers with a handful of large organisations. The relevant unit is the provider location, not the size of the parent organisation. A small local provider with a fair price, secure income, and compact geography can thrive; a large provider with scattered, below-cost work cannot.

The sustainable volume for a provider location varies with fee rate, geographic density, and operating model. At an average state-funded fee of £25.00 per hour, Homecare Association modelling and providers' practical experience indicates that a typical location may need roughly 1,500-2,000 hours a week within a compact area; higher fee rates reduce the volume required. This is an indicative viability range, not a quota or an argument for organisational consolidation.

In the near term, commissioners can organise work into sensible geographical neighbourhoods, with sufficient and reasonably predictable volumes for providers to build compact rounds and stable teams. Commissioners in some places have already done so with positive outcomes, an example of which we discuss below.

This is important not only for provider efficiency. It is what makes better employment possible.

When work is geographically dense and reasonably predictable, travel falls, mileage reduces, rota gaps reduce, and careworkers can be paid for a whole working round rather than a dispersed collection of contact minutes. Providers can offer more dependable hours. Sponsorship becomes more workable because employers have greater confidence in the volume of work available. Continuity improves for people receiving care, and stable providers can become genuine partners in neighbourhood health teams.

Be Caring: a promising bridge, not the final destination

The Skills for Care neighbourhood-based block-pay blueprint, based on Be Caring's work in Leeds, Manchester, Bradford and Sheffield, shows what can be achieved before a full outcomes architecture is in place[19]. Contracts concentrate work geographically and typically guarantee a minimum volume; Be Caring then pays careworkers for the whole round, including travel, reasonable gaps and training, and shares open-book utilisation data with commissioners.

The model has produced encouraging results. In Leeds, the proportion of paid time spent with people rose from 64% to 84% between 2020 and 2024; reported length of service increased by 27% to 3.3 years; and over 98% of people surveyed said they were treated with dignity and respect. Trusted assessors can review and right-size packages more quickly, and the integrated outcomes process records personalised goals and supports continuous improvement. The CQC rated Be Caring's Leeds service as Outstanding, which is rare for state-funded homecare providers.

It remains a bridge rather than a complete destination. The toolkit states that contracts remain based on hourly rates and hours delivered, generally with guaranteed volumes, and that payment is still per call in most locations, supplemented by retainers. Outcomes inform care planning and review but do not yet determine a risk-adjusted per-person budget or a material payment adjustment. Nor does the model itself give the individual control of a portable budget across a curated provider network.

Government should therefore use the blueprint as a practical transition platform: first secure neighbourhood volume, whole-round pay, trusted assessment and shared data; then test standardised assessment, consumer-directed budgets and balanced outcomes-linked payment on top. This would build on a working model rather than attempting a big-bang replacement of current commissioning.

Step two: establish a fair price

Choice and innovation cannot flourish if the underlying price is unsustainable.

[19] Skills for Care (2026). Practical approach: Neighbourhood-based block-pay.

We continue to advocate a National Contract for Care Services, with a transparent method establishing a minimum price below which public bodies cannot purchase regulated care.

To be effective, a minimum price also needs a proportionate and accessible route for providers to challenge purchasing below it, short of the cost and delay of judicial review. This could form part of the National Contract for Care Services, for example through a transparent escalation and resolution mechanism.

The contract must specify not only the headline rate but also the unit and trigger for payment. A theoretically adequate hourly rate can be eroded if income is reconciled to exact contact minutes, if short visits attract too little for per-visit travel costs, or if providers must hold capacity without a retainer or guaranteed volume. The price floor should therefore be accompanied by model payment clauses for planned time, hospital admissions, cancellations, exceptional needs, travel, and statutory cost changes. Any national price floor and statutory-cost adjustment must be reflected in local government and NHS funding settlements, so that a fair price does not become an unfunded obligation on councils and ICBs.

Local flexibility about organisation of services should remain. Local authorities understand their communities. But there should not be local discretion to purchase a statutory service below the cost of complying with national employment, immigration, and care legislation.

Government would not expect another publicly commissioned service to meet mandatory national standards from a contract priced below the direct employment cost of the workforce required to deliver it. We should not accept that approach for personal care and healthcare delivered to older and disabled people at home.

Step three: turn fair funding into secure income for careworkers

A Fair Pay Agreement can determine the headline pay rate of a careworker. Commissioning determines whether they can have enough total income and security of income in a decent working week.

The aim should be for careworkers to be paid for a round: from the beginning of their work to the end, including contact time, travel, reasonable waiting and training.

Commissioners need not purchase every workforce minute directly, but the payment envelope must be sufficient and predictable enough for the provider to do so. In an outcomes model, efficiency gains should come from better routing, prevention and right-sizing support with the person - not from leaving travel, waiting or cancelled work unpaid.

That is much closer to how we understand other public services to work. We do not pay a district nurse only for the minutes spent in a patient’s house, or a refuse collector only while emptying a bin.

A worker with a guaranteed contractual hourly rate but a fragmented rota, large unpaid gaps and unpredictable weekly hours has not achieved a fair wage and genuine employment security.

This is also why commissioning reform is essential to both the Employment Rights Act and the immigration system. A provider cannot guarantee its careworkers hours that nobody guarantees to it.

Better neighbourhood commissioning therefore improves employment conditions through better work organisation and productivity rather than just transferring greater legal and financial risk onto providers.

Step four: regulate fairly and give citizens trustworthy choice

The final piece is regulation.

Consumer-directed care depends on people being able to distinguish safe, high-quality provision from poor provision. Yet the present market has two serious weaknesses: parts of personal care provision operate outside normal care regulation altogether[20], while over four in five registered community social care services do not have a current CQC rating[21].

Safeguards should be proportionate to the activity performed and the risk it carries, rather than determined by the employment or commercial model alone. A person receiving personal care should have appropriate protection whether the worker comes through a CQC-registered provider, an introductory agency, a commercial intermediary or an individual worker responding to a social media advertisement. The aim is to close the gap exploited by commercial models that arrange personal care while avoiding equivalent oversight, not to require every directly employed personal assistant to register with the CQC. Instead, introducing a professional register for individual careworkers would add safeguards for consumers and add to national data on careworkers and people drawing on services, which is also important for emergency planning and response.

This is becoming more important as other policies push workers to the edges of the regulated market. Immigration enforcement, employment costs, and inadequate commissioning should not create a commercial advantage for informal, self-employed, or unregulated models.

The CQC needs sufficient capacity to assess quality and enforce care regulations. A curated local market of quality-assured providers would make consumer choice more meaningful and regulation more achievable than a hyper-fragmented market of between 14,000 and 15,000 non-dormant locations with limited current information about quality.

[20] Townson, J.K. (2023). Unregulated homecare.
[21] Townson, J.K. (2026). Unseen and unrated: more than four in five community social care services in England have no current CQC rating.

Australia's National Disability Insurance Scheme illustrates the opposite risk. An unusually open, individualised market grew to around 150,000 unregistered providers alongside 16,000 to 20,000 registered ones, with provider-led demand, over-servicing, and rising individual budgets[22]. The Australian government is now moving some services back towards commissioned models on grounds of fiscal sustainability and quality. The lesson is not that consumer direction is wrong, but that a highly fragmented market of largely unregulated providers is neither self-regulating nor sustainable. A curated, quality-assured network is a safeguard, not an incidental feature.

Commissioning connects all of this

This is why we see commissioning as a pivotal reform.

Get it right and many apparently separate policy problems begin to align: citizens gain meaningful choice and better quality and continuity; providers gain predictable income, which supports sustainability; careworkers gain more regular work and secure earnings; sponsorship rules become more deliverable; commissioners gain productivity; regulators face a more manageable market; and homecare providers can become stable partners in neighbourhood health.

Get it wrong and Government can spend more while still buying fragmented minutes; strengthen employment rights while employment remains insecure; negotiate higher pay without ensuring providers can fund it; tighten immigration enforcement without changing the conditions generating compliance risks; and promote consumer choice in a market where people cannot reliably judge quality.

No department acting alone can resolve this. Immigration rules, employment rights, the Fair Pay Agreement, local government finance and reorganisation, local authority and NHS commissioning, procurement policy, and care regulation are currently interacting in ways that no individual provider controls.

What we ask Government to do

Publish model payment clauses and commissioning guidance now. Councils should not have to wait for a complete outcomes system to stop exact-minute purchasing, fund planned capacity, protect income during short hospital stays and cancellations, or calibrate short-visit and rural payments to actual cost.

Develop national standards and models for neighbourhood commissioning and contracting that support better employment for careworkers. DHSC, working with the Ministry of Housing, Communities and Local Government and NHS England, should, with people who draw on care, providers and commissioners, co-

[22] Commonwealth of Australia, Department of the Prime Minister and Cabinet (2023). Working together to deliver the NDIS - Independent Review into the National Disability Insurance Scheme: Final Report.

design a National Contract for Care Services that joins a verified cost floor to minimum standards for market shape, payment mechanics, data, outcomes, workforce security and annual statutory-cost adjustment.

Establish neighbourhood demonstrators. A small number of council and ICB areas should test the complete funding flow: assessment sets a portable personal entitlement; the person directs it to a chosen quality-assured provider; the provider is paid prospectively for assessed need and planned capacity; and outcomes, experience and quality influence a modest adjustment. Demonstrators should also test the balance between a portable, person-level payment that follows individual choice and a neighbourhood capacity payment that sustains resilience and workforce stability, whole-round pay, provider flexibility, shared outcomes data and independent evaluation. Shadow outcome payments should precede financial incentives so the dataset and risk adjustment can be validated safely. These demonstrators should be centrally funded, so that testing better commissioning does not depend on individual council budgets.

Align policy across government. DHSC should lead a cross-government programme, with a named senior responsible owner and published implementation timetable, so that the funding settlement, Fair Pay Agreement, Employment Rights Act, immigration sponsorship requirements, welfare rules, public procurement policy, CQC capacity, and NHS neighbourhood policy are tested against the same commissioning architecture. Because procurement policy is owned by the Cabinet Office, it should be a partner in this programme, so that procurement rules reinforce rather than cut across fair commissioning.

The Homecare Association has extensive data on costs, commissioning practices, workforce issues, and market sustainability across the country, alongside examples of better approaches already operating in parts of England. We would be very pleased to work with the Minister and officials - together with commissioners, providers and people drawing on care - on practical models for neighbourhood commissioning, consumer-directed care, per-person funding based on assessed need, a National Contract for Care Services and fair regulation.

These may sound like technical decisions about purchasing. In reality, they determine whether Government can deliver some of its biggest ambitions for social care: quality, choice, a valued workforce, prevention, fair employment, effective immigration controls, and joined-up neighbourhood care.

We would therefore welcome the Minister’s leadership in bringing these strands together around commissioning reform, rather than addressing their consequences separately.

There is a particular risk in sequencing. Strengthening employment rights through the Employment Rights Act is welcome, but if it takes effect while the state continues to purchase homecare by the contact minute, providers will acquire new duties towards their workers without the secure, predictable income needed to meet them. The likely results are further handbacks, provider failure, and reduced availability of

care, rather than the better employment the reform intends. Aligning commissioning reform with the Employment Rights Act is therefore essential to realising its benefits and avoiding unintended harm.

If we want different outcomes, we must change what the state buys.

Appendix 1 - glossary of contract types

- **Framework**: an eligible list of providers who can bid for contracts, but without a guarantee of work. In a closed framework, providers can join only when it is established; under the Procurement Act 2023 an open framework can be reopened to admit new providers during its term. Call-offs may be awarded with or without further competition.
- **Spot**: a single purchase with no guarantee of hours. Public bodies often use this contract type for care limited to a particular length of time, a defined area or a specific person needing services.
- **Block**: guarantees a volume of hours, capacity or a defined service at a prearranged price.
- **Lead provider**: a single provider is responsible for services in, say, a specific area, but can subcontract some work to other providers.
- **Dynamic purchasing system**: similar to a framework, but providers can join the eligible list at any time. Under the Procurement Act 2023, dynamic purchasing systems have been replaced by dynamic markets for new procurements, and now operate only as legacy arrangements.
- **Approved provider list**: similar to a framework, but without a contractual agreement for future work.

Appendix 2 - Oldham: commissioning and contracting model

Oldham's 2026/27 homecare tender uses a neighbourhood model with two lots. Lot 1, Care at Home, commissions daytime homecare at £25.00 per hour and pays by the recorded minute through Electronic Call Monitoring, so a 30-minute call delivered in 25 minutes is invoiced as 25 minutes. Lot 2, Night Care, is a block contract at £9,800 every four weeks (£127,400 a year) for two careworkers on every eight-hour night shift, 365 nights a year, delivering at least 14 half-hour visits a night across the borough, with the provider supplying a vehicle and equipment.

The design illustrates the paper's central point about the payment mechanism. The Council purchases capacity at night, recognising that it is buying availability rather than activity, but pays for the same underlying capacity by the minute during the day, even though daytime homecare requires responsive capacity in the same way.

Paying only for utilised minutes leaves the provider carrying the cost of maintaining that capacity, and sets the recorded-minute incentive against the accurate utilisation data the Council itself seeks. At £25.00 per hour, Lot 1 also sits below the £26.17 direct cost of employing a careworker before any overhead.

The night-time homecare contract price is 16% below the modelled cost of placing two careworkers on every night of the year, an annual shortfall in the order of £24,776, and therefore risks viability and service continuity.

Appendix 3 - Redcar and Cleveland: commissioning and contracting model

Redcar and Cleveland changed its payment mechanism on 31 August 2026, ending the 15-minute minimum payment and five-minute rounding under its Home Care Visits Module so that providers are paid solely for the exact minutes recorded. The 2026/27 rates are £23.04 per hour for long calls and £26.24 per hour for short calls, against a Minimum Price of £34.42; the long-call rate sits below even the £26.17 direct cost of employing a careworker lawfully.

The example shows why the payment mechanism, and not only the headline rate, determines viability. The costs of a visit - travel, waiting time, mileage, recruitment, training, supervision, scheduling and compliance - are fixed when the visit is planned and do not fall when a call ends a few minutes early, so paying by the recorded minute transfers an unfunded shortfall to the provider. Because travel and mileage form a larger share of each hour on shorter visits, minute-by-minute payment removes paid minutes from precisely the calls that already cost most per hour to deliver.

Appendix 4 - Derbyshire: commissioning and contracting model

Derbyshire proposes to replace its current model - £22.82 per contact hour plus a separate travel payment banded by rurality, from £3.50 urban to £6.80 extra-rural per visit - with a single combined hourly rate of £27.77 urban, rising to £32.53 extra-rural, with cancelled calls paid at £22.82. The change would be made by written variation to a ten-year framework only a few years into its term, with a full re-procurement as the stated alternative if agreement cannot be reached.

The example shows how the allocation and payment structure, and not only the rate, shapes delivery. The proposed urban rate sits about 19% below the Minimum Price of £34.42, and further below it once the Council's own higher contact-wage assumption of £13.50 is applied on a like-for-like basis. Folding a banded travel payment into a single blended hourly rate reduces payment most for the shorter and more rural visits, which carry the highest travel and mileage cost per hour of care, so the model bears down hardest on the visits that are most expensive to provide.

Shaping homecare together

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