Complex people don't exist. Unstable systems do.

A briefing on stability, funding, and the conditions for ordinary life

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Vinesh Kumar

I Direct Independent Living
South West of England
March 2026

This briefing is drawn from the full essay of the same name. It is written for anyone who commissions, provides, or shapes complex care – whether in local authorities, NHS commissioning bodies, provider organisations, or policy roles – and for families whose relatives receive support. It sets out a practical argument: that instability in systems produces the complexity we attribute to people, and that investing in the conditions for stability is a better use of public money than paying for crisis after the fact.

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THE CORE ARGUMENT

This briefing comes from a decade of founding and running a care organisation in the South West of England, supporting people whose lives are often described as complex. The central argument is simple: most of what gets labelled as complexity in a person is produced or intensified by instability in the system around them. When relationships churn, decisions come late, and judgement is pushed away from everyday life, the system creates the very problems it then struggles to manage.

We have seen it repeatedly. When conditions around a person become stable – even imperfectly – life often becomes calmer and more ordinary again. Nothing fundamental about the person changes. The system around them does.

The practical question for anyone responsible for how care is organised is not whether people have difficult lives. They do. The question is whether the way we purchase, provide, and oversee support is making those lives harder than they need to be, and whether the cost of that instability is being disguised as inevitable pressure.

WHAT STABILITY MEANS IN PRACTICE

Stability is not a feeling or an aspiration. It is a set of conditions that can be funded, protected, and measured. In our experience, five things hold a person's support steady under pressure:

- **Continuity of relationship.** The same people stay involved long enough to know the person, read the patterns, and act early. When relationships churn, learning leaves, and the system has to start again.

- **Judgement close to everyday life.** Frontline colleagues who know the person well can adjust support in real time, without having to escalate every decision up a chain where it lands late and often lands wrong.
- **Leadership presence where the work happens.** Leaders who are close enough to the work to notice drift early, set a moral tone through action, and support colleagues when judgement does not land neatly.
- **Psychological safety.** Colleagues who can name concerns early, plainly, and have those concerns treated as responsibility rather than disloyalty. Most systems fail quietly before they fail publicly.
- **Investment in people.** Treating frontline colleagues as professionals with judgement, temperament, and experience worth developing and retaining, rather than as interchangeable costs to be managed.

When these conditions hold, small adjustments happen early. When they do not, small shifts become drift, drift becomes crisis, and crisis becomes the expensive emergency that everyone later describes as unavoidable.

THE ECONOMIC CASE

Instability is expensive, and the bill always appears somewhere, even when it is delayed or disguised. Much of the system responds to crisis with emergency placements, one-off packages, and rushed decisions made under pressure. Cost rise and outcomes worsen, not because people are careless, but because the system keeps paying for the same

problems late, after judgement and continuity have already been squeezed out.

What made the difference economically for us was predictability, and it came from stability. Relationships stayed in place long enough for people to learn properly. Judgement stayed close to the frontline, where reality was visible, rather than being escalated late to people who could only see a version of it through forms and risk language. When judgement is close, small adjustments get made early. When judgement is distant, the system waits until a situation is serious enough to justify escalation, and then it pays more.

A steadier system meant fewer crises, fewer emergency decisions, less duplication, and less of the costly back-and-forth that happens when risk is pushed between provider and placing authority, with each side trying to protect itself. A lot of so-called savings in social care are simply costs moved elsewhere until they return as crisis. The difference was building stability earlier, so we were not constantly paying for the same problems twice.

In a system under financial strain, being serious about stability is a responsible use of taxpayers' money. It moves money away from crisis and into the quieter work that lasts.

WHERE THE LEVERAGE SITS

No one can buy stability by guessing who will be good, and no one can buy it by writing longer specifications. But commissioners, providers, and those who set policy can fund and protect the conditions that make stability more likely and stop arrangements that quietly drive instability.

In practice, that means funding continuity and expecting leadership presence that is real, not remote. It means insisting that frontline colleagues are listened to, because judgement lives there. It means protecting space for discretion rather than squeezing it out with process. It means avoiding procurement that rewards bid writing and

scale over learning, judgement, and the ability to hold a person's life steady.

It also means keeping the conversation anchored in what is happening now, not only what was promised in a tender. Over the next couple of years, the temptation will be to treat faster technological tools as a substitute for stability, when the real cost control still comes from continuity and early judgement.

Publicly funded care should not become a vehicle for value extraction. The issue is not whether investors exist, but the structures that pull money out while leaving risk and instability behind. If the funding is public, the discipline should be public too, with fair tax, transparency, and reinvestment in the conditions that make stability possible.

Providers carry a responsibility here too. The conditions for stability are not only purchased from outside – they are built and held from within. Investing in your own people, protecting continuity when it would be easier to rotate staff, keeping leadership close to the work rather than remote from it – these are choices providers make every day, and they matter as much as anything a commissioner can specify. Families, meanwhile, often see drift before anyone else does. Their observations deserve to be treated as evidence, not as complaint.

SIGNALS: AN EARLIER LAYER OF ATTENTION

Traditional performance measures, KPIs and outcome metrics, often arrive too late to help. They tell you what happened after the fact. They miss what is happening as life unfolds: the small shifts, the pressure building, the quiet delays, and the way decisions get pushed upwards until nothing moves.

We developed what we now describe as signals: a way of noticing drift early, while there is still time to act. They are not a scorecard, and they are not a compliance tool. They sit alongside formal measures as

prompts for attention, focused on the conditions that make good support more likely.

The questions they prompt are practical. What is changing? What is holding or drifting? What support is needed now to prevent escalation? Used well, they keep the conversation grounded in everyday reality, making drift visible sooner while there is still time to act.

Eight signals of system stability

	Signal	What to Notice	Why it Matters
1	**Continuity around the person**	Key people stay involved over time. Familiar faces in day-to-day support. Fewer crisis-driven changes.	When relationships are stable, lives tend to stabilise. When they churn, complexity rises early.
2	**Judgement close to everyday life**	Decisions taken in real time. Frontline colleagues can explain why, not just what. Routine judgement not pushed up for approval.	Excessive escalation usually means people do not feel trusted to use judgement.
3	**Leadership presence where the work happens**	Leaders visible in ordinary settings. They understand the person and context, not just the paperwork. Consistent messages under pressure.	Tone travels faster than policy. Leadership behaviour sets the limits of judgement.
4	**Psychological safety and speaking up**	Concerns raised early, before incidents. Disagreement possible without consequence. Silence treated as a risk, not reassurance.	Most systems fail quietly before they fail publicly. If people cannot speak, blind spots become normal.
5	**Learning stays in the system**	Turnover low enough for skill to build. Internal progression normal. Long-serving colleagues hold meaningful roles.	When people leave, learning leaves with them. Stability allows knowledge to accumulate.
6	**Colleagues treated as trusted professionals**	Investment beyond the bare minimum. Roles shaped	Support quality depends on judgement and

		around capability. Pride in good work, not box-ticking.	capability, not process alone.
7	**Families and circles of trust treated as partners**	Families know who to contact and trust that relationship. Paid support strengthens, rather than replaces, informal relationships.	Families and trusted others often hold vital knowledge long before services become involved.
8	**Working relationships across organisations**	People across agencies know each other well enough to work quickly. Problems solved collaboratively, not pushed into contracts.	Fragmentation shows up at organisational boundaries first, and instability grows fastest there.

A FINAL WORD

We have not solved these problems, but we have learned one pattern again and again: instability causes complexity more often than people do. When systems hold well, it becomes easier for people to live ordinary lives.

The full essay, from which this briefing is drawn, sets out the thinking behind these ideas in more depth, including reflections on citizenship, moral judgement, the value of work, and the role of technology. It is available under *Creative Commons* licence.

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