The conditions for an ordinary life

An essay on commissioning, citizenship and the duty that has moved.

Vinesh Kumar

I Direct Independent Living

South West of England

June 2026

A companion paper to Complex people don't exist. Unstable systems do.

Foreword

by Dr Simon Duffy

Dr Simon Duffy is the founder of the Centre for Welfare Reform and Citizen Network. He has spent over thirty years working to advance citizenship and self-directed support for disabled people.

This essay is too rich to synthesise, but one phrase jumped out at me, echoing the great British philosopher FH Bradley, "one's station and its duties." We are asked to reflect on our role and our true responsibilities. We are asked in particular to examine a role that rarely gets much attention, the role of a commissioner in health and social care services. We are offered a deep and detailed account of what that role could become that will challenge some but inspire others.

We are at a turning point in our society and in the evolution of public services: we are at the end of the neoliberal era where human judgement and ethical responsibility were sacrificed to quasi markets and procurement processes. When I meet people of my generation, operating at a senior level in public services, we share little doubt, the systems that were established in the 1990s do not work: the changes promised were unfulfilled and the problems created have become too large.

Of course, the challenge is to outline where we go next. There are many forces at work, for good or ill, and this essay recognises many of them. However, what is demonstrated here is what Hannah Arendt describes as the faculty of judgement. Vinesh Kumar is paying attention to what is real; he is not being driven by ideology, theory or enthusiasm. Instead, he is looking in detail at the moral challenges we face in the context of real life, real care and real relationships.

There is no tilting at windmills here. The essay offers pragmatic, affordable and ethical solutions. It also clarifies exactly the right shape of our responsibilities, the need to pay attention to those things that the old system has ignored: our citizenship, our neighbourhoods, and the workforce, upon which everything of value in the system depends. This is the most compelling account of what commissioning could be that I have ever read.

1. Why this essay exists

This essay continues a question I started in another paper but did not finish. In *Complex people don't exist. Unstable systems do.* I argued that most of what we describe as complexity in a person is produced or intensified by instability in the system around them. When relationships churn, when judgement is pushed up a chain, when learning leaves with every departure, the system creates the very difficulties it then struggles to manage. I tried, in that paper, to set out what stability looks like in practice. I did not say enough about commissioning, which is the part of the system that decides whether stability is funded, protected, or quietly squeezed out of existence.

It is fair to say, before going further, that we have made real strides over a generation. The long-stay hospitals of forty years ago have largely been closed. Many thousands of people with a learning disability or a long-term mental illness now live in their own homes, on tenancies separated from their care, in communities they helped to choose, with circles of family and friends and colleagues around them. Some are in work. Some are voting. Some are getting married and raising children. That work was hard won, by disabled people themselves, by their families, by a generation of policy that took citizenship seriously for the first time in this country, and by providers who chose to be on the right side of the argument when it was not easy. None of what follows in this essay is a denial of that progress. The argument is that the architecture which made some of that possible has not been completed, and the work has not yet reached everyone.

I am writing about commissioning now because the gap matters more in learning disability and long-term mental health than almost anywhere else. The people whose lives I have spent a decade trying to support are the people for whom instability has the heaviest consequences. They cannot articulate what is wrong while there is still time to act. They cannot exit a poor provider in the way an ordinary consumer can. They are the people for whom citizenship has to be held

by someone they trust, because they often cannot hold it themselves. The way the public system commissions support for them is in a worse state than it has been for at least a decade, and the architecture is fragile both at the visible end and across the wider community.

The specific evidence I draw on, and the scandals I name, are from that part of the system. The architectural argument travels wider, into older people's care and adult social care more generally, but I have not tried to write that essay, and the reader for whom the wider arguments are useful is invited to translate them.

The essay does not attempt the full account of race, ethnicity and migration that the lives of the people it is about deserve. That remains a real limit of its scope. The position of the overseas workforce, however, is faced directly in the section on culture and the workforce, because the argument cannot be made honestly without it.

The visible failure, and the one most often quoted, is the inpatient population. As I write this, around two thousand one hundred people with a learning disability or autism live in mental health hospitals in England. Many have been there for years. Almost half could be in the community, if the community provision around them held. Each placement costs the public purse around a quarter of a million pounds a year. The less visible failure, which has to be said in the same breath, is that the community provision which did succeed in moving people out of institutions a generation ago has not been resourced or designed to hold the next generation and is now running on the energy of the workforce, the families and the people supported themselves. The same architectural choices that leave the inpatient population stuck also leave thousands of communities lives held by very little. We pay for the failure to commission stability every day, at the most expensive possible price for those at the visible end and at a hidden cost for everyone else, and we describe the bill as inevitable.

This essay is, then, an argument about commissioning, but it is not a paper about procurement. It is an argument about what commissioning is for, and what it

could be if we took citizenship seriously and stability as its precondition. It is written from practice rather than from theory and from more than one vantage point within it. I began in provider services. From 2009 to 2014, I worked as a consultant across health and social care, in local authorities and provider organisations, in primary care and inside the new commissioning bodies being set up, through the years in which personalisation was being implemented, and public health was moving into local government. Since 2014 I have built and corrected a provider from the inside. The years of reading I am still in the middle of came after all of it. The people whose work has shaped my thinking are named at the end.

2. Citizenship, and the question commissioning forgot

The question public commissioning was originally meant to answer is one we have, in the last forty years, almost stopped asking. The question is not how to buy services efficiently. The question is how a public system can secure for each person it is responsible for the conditions of an ordinary life. It treats the person as a citizen with a claim on the public, rather than as a service user with a need to be processed.

The older British moral tradition would recognise this question. Morality, in that tradition, is not abstract individual choice but is constituted by one's station and its duties, the role one occupies in real institutions, and the obligations that flow from them. We tend to forget this in modern policy, where citizenship gets spoken about as if it were a transaction between an individual and the state. It is not, and it never was. It is held in real institutions, in real relationships and in real places, and the conditions of those institutions decide whether citizenship can live or not.

The conditions of an ordinary life are not difficult to name once you have spent time with people who have been denied them. The

ability to direct one's own life. A sense of direction. Money sufficient to make ordinary choices real. A home of one's own. The support of people who know you. Membership of some kind of community. Different writers have set these out in different forms across the last quarter-century, and the same set has been worked through, in more or less the same form, into the reform programmes of New Zealand and Australia. They have been less successful in the country where they were first set out in this form. Here citizenship was quietly translated into "personalisation," and personalisation, equally quietly, into "the personal budget." A frame about authorship over a life became, in implementation, a mechanism for buying services through a different transactional door. Academic observers were documenting this translation as it happened. What follows is the practitioner's version of what they saw from outside, from someone who was inside the local authorities while it was done.

The reason this matter for learning disability and mental health is not abstract. A great many of the people I support cannot exercise consumer choice in the way personal-budget orthodoxy assumes. There is a way of describing what is missing here. There are three responses available to anyone dissatisfied with a firm or a service: leaving, complaining within, or staying because of attachment. Markets work, when they work, primarily by the first of these, exit, which keeps quality honest because customers can take their money elsewhere. The people I am writing about cannot exit. Many cannot voice. *What is left is the loyalty of those who hold their interests for them, and that is no longer a market relationship at all. It is a relationship of trust, exercised by someone else on their behalf*. So, if you make their citizenship depend on their behaving as consumers, you are saying, in effect, that they do not get to be citizens. That is not what the original argument was. It is what the implementation made of it.

The better reading, and the one I want to argue for in this essay, is that citizenship for these people has to be held by someone they trust.

That holder might be a family, a circle of friends, a long-standing worker, a small local organisation, or a steward in the state. The holding is the work. A public system that takes their citizenship seriously cannot be a transactional one in which the state purchases units of activity from a market. It has to be a system that funds and protects the conditions under which citizenship can be held. The most important of those conditions, as I have argued elsewhere, is stability.

Citizenship, in this reading, is not only about what is held for someone. It is also about what they contribute back, the work they do, the friendships they sustain and the small gifts they make to the place around them, all of which the system has to recognise as real even when they do not fit conventional measures of productivity.

3. Stability as the condition

I do not think stability is one good idea among many. I think it is the condition that makes the others real.

A person can have a beautifully written support plan, a generous personal budget, an attentive social worker, an outcome dashboard the inspector admires and still have a worse year than the one before, because the people who knew them left; the people who replaced them did not know the early signs; and the small adjustments that used to be made early were now being made late and then not at all. The plan still says what the plan said, the budget is intact, nothing on the page has gone wrong, and the person's world has shrunk anyway because the conditions that allowed an ordinary life to be sustained have quietly drifted apart.

Stability, in the sense I mean, is not a feeling and not a slogan. It is a set of conditions that can be named, funded and protected. I have written elsewhere about eight of them: the continuity of relationships around the person, judgement close to the work, leadership presence where the work happens, psychological safety in the team, learning that

stays in the system, professional respect for colleagues, families and circles of trust as partners, and working relationships across agencies that actually function. These are not soft preferences. They are the conditions that decide whether a small change becomes a calm adjustment or an emergency placement.

What follows is that you cannot buy citizenship without funding stability. You can give a person a budget, but if the support team changes every six months, the choices the budget represents do not land in their life. You can write a contract demanding "personalised outcomes," but if the people delivering the support are paid at the floor of the labour market and treated as interchangeable, those outcomes will not survive the turnover. You can pay for the visible end of a service while quietly defunding the chain of human conditions that produces it. We have done so for so long that we now describe the consequences as cost pressure, as if the bill had arrived from somewhere we could not see.

The simple version is this. *Stability is the condition for citizenship. Citizenship is the point of commissioning. Commissioning is the public function that can either fund and protect the conditions for stability or carry on buying services from inside a system that erodes those conditions every day.*

The deeper psychological tradition has been pointing at the same idea for nearly a century. The holding environment described in mid-twentieth-century developmental psychology, the continuity, the predictability, being known by the same people across time, and the slow accumulation of trust is not just about children. The same conditions are what allow adults, and particularly adults with profound learning disability or long-term mental health needs, to live ordinary lives. What I am calling stability in care is, at its deepest level, the holding environment translated to adulthood and to public systems. Attachment theory has carried this finding through decades of clinical and developmental work, and it is the psychological evidence base behind the practitioner truth this essay is written from.

There is a wider literature behind this argument that I did not read my way into but arrived at independently from practice and which has nonetheless reached, by its own road, conclusions close to the ones I have set out here. Writers on the erosion of character under flexible capitalism, on the conditions for sustained meaningful work, on attachment theory and its evidence base, on person-centred planning in disability practice, on what holds places and communities together over time. The argument here owes more to those traditions than the brevity of the references section can fully acknowledge. They are listed at the end.

4. Economics, prudence and what can be done now

The argument I am making has a moral edge to it, but it also has an economic one, and I want to set that part out plainly, because the economic argument is the one commissioners actually have to make to anyone above them.

What we are doing now is not cheap. The half a billion pounds a year we spend keeping people in mental health hospitals they do not need to be in is the most visible number. Behind it sits a much larger one. The cost of placements that break down because the support team turned over. The cost of safeguarding incidents is the early signals missed. The cost of crisis admissions no one saw coming because no one was close enough to see them. The cost of agency staff filling the gaps left when permanent colleagues leave a workforce we built to be temporary. The cost of repeating, year after year, the same procurement round that produces the same kind of provider. The cost of out-of-area placements bought in haste because no local provision could be found in time. None of these are accounting fictions. They are the public money the system actually spends on the failure to commission stability, paid at the most expensive end of the chain, recorded as cost pressure as if the bill had arrived from somewhere else.

The honest claim, and the one I want commissioners to be able to make in their own teams and in front of their political masters, is that funding the conditions for stability is not more expensive than not funding them. It is significantly less expensive. The trouble is that the savings show up in budgets the original commissioner does not control. A community placement that holds means a hospital admission that does not happen, but the saving falls to a different line in a different organisation in a different year. The architecture rewards the visible spend and ignores the avoided one. That is the shape of the financial trap we are inside, and it is worth saying out loud, because the trap is the reason most commissioners feel they cannot afford to do what they know would work.

There is also the methodological objection that a Treasury-trained reader will raise at this point, which deserves a direct answer. The empirical evidence for the savings I am claiming, they will say, is thin in the controlled, sector-specific form that public spending decisions are supposed to require. The evidence base for stability as the condition of good care does exist in many forms. The historical record across thousands of years of collapsed civilisations shows the same pattern repeatedly. The cross-sector industrial evidence of the service profit chain shows that staff conditions determine what users experience. The lived evidence of every family, every settled team, every long-running school, every village that has held together, that continuity and judgement close to the work are the conditions of a flourishing institution, is unmistakable to anyone who has spent time in or near one. None of that is the kind of evidence the Treasury counts as evidence in the narrow sense. But it is overwhelming evidence in the sense that matters. The methodology that demands narrow proof before acting on a structural truth is itself the methodology that has produced the system now failing. Thirty-five years of narrowly framed evidence-based commissioning have not prevented the inpatient figure with which this essay began. *The answer to the question, is your evidence good*

enough, is that the system we have built on the previous evidence base is the strongest argument against the methodology that built it.

It is fair to ask what commissioners can do about any of this with the budgets they actually hold. Local authority adult social care budgets have been squeezed for fifteen years, and the argument that more money is needed at a national level is true and has been true for a long time. But there is also a significant amount that can be done with the money already in the system, and I want to set out what some of that looks like, because the worst version of this argument is the one that waits for the Treasury before it begins.

Lengthen contracts where you can. The single act of giving a provider a five-year horizon rather than a three-year one is among the cheapest commissioning decisions there is, and it pays for itself, because a team that knows it has time to settle invests in itself differently from a team running to the end of a contract.

Move some of the spend on monitoring into development. The compliance machinery we have built consumes a real share of every contract on both sides. A modest portion of that, redirected into supporting providers to build the workforce conditions that actually produce quality, has a return the audit version of the work does not have.

Use the flexibilities that already exist in the framework. Most procurement frameworks contain more discretion than they are used to expressing. Commissioners who lean into that discretion, who choose continuity over price-tendering for a particular person, who exit a poorly performing provider early and stay with a good one longer, who give weight to retention and not only to capacity, are doing the work of stability inside the architecture they have. It is incremental, but most real change is.

Pool budgets at the scale where pooling is possible. The full pooling of health and social care money is a national reform, and I will say more about it later, but a great deal can be done before that, at the

level of a place, between an integrated care board and a local authority, around a defined population. The Section 117 disputes that trap our most vulnerable people in administrative limbo can be resolved at this level, by agreement under the existing legislation, before any further statutory reform. It needs a will more than a new law.

Commission for the leading indicators of quality, not only the lagging ones. The outcomes you measure today are the result of workforce conditions three years ago. The workforce conditions you measure today are the outcomes you will see in three years. Contracts that ask providers about their turnover, their retention, their internal progression, their pay floor, and their reporting of near-misses are pricing in stability rather than only its absence. That is not extra money. It is the same money, spent on the part of the chain that decides everything else.

Use the social investment instruments that already exist. The British Business Bank, Big Society Capital, Power to Change, the start-up loan schemes, are sitting outside the care economy. Local authorities and integrated care boards can, with little or no new money, route applicants toward this capital and shape what gets funded so that the provision being built is the kind we have been describing. This is a market-shaping move that costs the commissioner almost nothing.

And hold the line on extraction. There is no commissioning policy that prevents the awarding of contracts to providers whose ownership structures, related-party charges and leverage are not visible. There is no policy that prevents the refusal of further work to providers whose money is leaving the country. There are existing local authority discretions on these questions. They are rarely used. They are free.

None of what I have just listed will fix the architectural problem this essay has been describing. The architectural problem needs the reforms I will come to in a later section. But the gap between what is possible now with current budgets and what is being done now with current budgets is real, and it is wider than most commissioning

departments admit. I am not pretending that any of this closes a sixty-million-pound funding gap in a council's adult social care budget. The wait for that gap to be closed at the national level is, for the people in our care, an expensive wait, and the work that can begin tomorrow with current budgets is the work that buys us time without buying us cost.

The wider economic argument, which I will not develop at length but should name, is that publicly funded social care will not be saved by efficiency in the current form. It needs investment, and it needs investment in the conditions for ordinary lives, not in another generation of compliance machinery. *The shareholder logic of the last forty years, the policy preference for technical and credentialled work over relational and embedded work, and the squeezing of place-based economies have all been corroding what we have.* The repair will eventually require national choices about money, about the workforce, about the pooling of health and care budgets, and about the place of care in the structure of the economy. Those choices are not in the gift of any single commissioner. But what every commissioner have, today, is the choice of what to spend their own current money on, and on what terms, and with what providers, and toward what end.

The money that buys an ordinary life is not the same as the money that buys cost containment. It is the money that buys the conditions in which an ordinary life becomes possible. That is the economic argument, and it is also, properly understood, the moral one.

5. The shape we built instead

What we have built in England, over thirty-five years, is a commissioning system whose internal logic is procurement. It does not see itself this way. It speaks of person-centred outcomes, co-production and choice. But its architecture is that of a buying function. The 1990 NHS and Community Care Act separated the part of the local state that

paid for care from the part that organised it. The local authority's job became to write specifications, run competitions, manage contracts and monitor compliance. The provider's job became to win contracts, deliver to the specification, and survive the monitoring.

I want to be careful here, because the argument is not that providers should never fail. The opposite. The renewal of any sector depends on a kind of creative destruction in which weaker or wrongly shaped organisations leave and better ones take their place. What I am pointing at is something different. The architecture we built does not measure the things that would let it tell the difference. It rewards the visible and ignores the structural. It rewards what can be measured and discounts what can only be lived. It rewards what can be procured in a contract round and quietly punishes what takes years of relationship to grow. So, the providers that struggle inside the system are often not the ones who would fail on any test that mattered. They are sometimes the ones doing the work as it should be done, but unable to demonstrate that fact in the language the procurement function understands.

The commissioning departments I know do try to shape the market. The trouble is that the instruments they have are the wrong ones. A framework round can sort by price and by stated capacity. It cannot see retention, judgement, leadership presence or relationship. So the provider that wins the round is often the provider best at winning rounds, which is rarely the same organisation as the one best at holding a life on the difficult days. Inside that frame, everything we now wish were different was made hard. Stability became impossible because contracts moved every few years and staff with them. Judgement was driven up the chain because the contract held the local authority accountable for everything. Learning evaporated because no one had reason to invest past the contract end. The market itself thinned, because the cost of bidding ate the energy that smaller, rooted, practitioner-founded organisations might have used to grow, and the field consolidated upward into a smaller number of larger, often distant

providers, who specialised in winning bids and managing compliance, and who treated the actual care as a downstream production cost.

The architecture, once chosen, makes its own logic. The honest description is that we built a procurement system and called it commissioning. We did so because it was easier than commissioning, and because procurement was the language Whitehall and the Treasury could speak, and because we had stopped asking the citizenship question. *This is not an argument that procurement should disappear. Procurement brings real goods to the system: transparency, comparability, anti-corruption discipline, and some structure around public money. The argument is that commissioning has become procurement-led, when procurement should be subordinate to the purpose of commissioning rather than allowed to define it.*

6. The two failures, the same failure

When systems fail at this scale and for this long, the politics of any given decade can push us toward solutions that are themselves the failure mode of the other side. In our sector this has produced a recurring argument between two poles, both of which the populist politics of recent years has made plausible, and both of which would fail in the same way if they were ever fully enacted.

The first pole is full nationalisation. Take the whole thing back in-house, run it as a state service. The appeal is real, particularly after another scandal in a private chain whose investors took out a dividend the same quarter the staff turnover passed forty per cent. But the largest state-run pieces of the system we already have, the inpatient assessment and treatment units and the long-stay mental health wards, are also the most expensive failures in it. State direct provision at scale tends toward institutional logic, toward distance from the person, toward judgement pushed upward and away from everyday life. The state is a poor direct provider of relational work, however good it can be as a guarantor of rights.

The second pole is full marketisation. Tighter contracts, lighter regulation, larger frameworks, capital from wherever it comes. The appeal here is also real, particularly after watching a commissioning department spend six months on a tender that produced no real change. But our experience of this is also clear. Concentrated private capital in care, particularly in private-equity ownership, has produced exactly the patterns this essay argues against. Complex group arrangements, related-party charges, leverage, churn-driving targets, money leaving the country to service debts taken on by people the residents never met. The collapse of Southern Cross in 2011 was not an accident. It was a structural feature of what happens when scale capital is allowed to consolidate in care.

There is a distinction the care sector would do well to recover, between institutions organised around acquisition, in which the point is what can be extracted, and institutions organised around function, in which the point is the social purpose the institution exists to serve. By that test a care organisation justifies itself not by the return it generates for those who own it, but by the lives it sustains and the citizenship it secures. Some of what we now call provision fails that test plainly. Some of what we admire as scale is, on that distinction, the wrong kind of organisation at the wrong end of the market.

Both poles, however differently they speak, share a feature that is the actual cause of their failure. Both centralise power. Both push decisions away from the person. Both make providers that are organised to keep judgement close to the person, of whatever size, structurally harder to sustain. The state monolith and the private-equity chain are the same shape, viewed from inside the home of someone whose support has broken down.

There is a longer historical reading of this that is worth holding in mind. Historical studies of why civilisations collapse have, looking for the single thing that explained their fall, repeatedly arrived at the same pattern. They did not fall to invasion. They collapsed from within,

when power concentrated, when wealth was extracted upward, and when the people closest to the work, the ones who knew the ground, lost the ability to shape what happened to it. *Centralised power that loses contact with what it governs is a structural failure mode, not an accident of a particular era. It is what state monopolies and private-equity chains have in common, and it is what our sector is at risk of repeating in slow motion.*

I should be careful about the size question here, because the argument is not that all large organisations are bad and all small ones are good. Some large providers are structured for the kind of work I am describing, organised internally into small, locally accountable teams, with judgement held close to the person, money reinvested in the people doing the work, and accountability that runs upward to a citizen rather than to a shareholder. Some small providers are badly run and worse for the people they support. The test is not size. It is extraction and responsiveness. Are the conditions for an ordinary life being held inside the organisation, or are they being squeezed out for someone else's benefit? Can the organisation act in real time on what it learns about a person's life, or does it have to escalate everything to a centre too far away to feel it? Those are the live questions. The design challenge that follows is also worth naming, because it is the harder one. It is how to scale without losing responsiveness, and how to keep citizenship and stability alive at fifty colleagues, at five hundred, at five thousand. Some organisations have done that, by splitting rather than layering, by building federations of small, accountable units rather than a single hierarchy. That is the kind of scale worth defending.

The most striking example I know of this design is not in social care at all, but in eye surgery in southern India. A single organisation has built itself, over fifty years, into a federation of hospitals that perform more cataract operations than any other in the world, at world-class quality, at a fraction of the cost, on a model that funds free care for the poorest patients from the modest fees of those who can pay. The achievement is not the scale on its own. It is that the scale has

been built on disciplined relationship to a purpose, on respect for the people doing the work, and on a refusal to sacrifice the quality of the surgery to the quantity of the surgery. The principles are not specific to eye care. They are the principles a serious care economy could be built on.

The argument worth making is therefore not state versus market. It is centralised versus plural. The defensible position is a public system that funds the conditions, regulates honestly, and protects a plural, place-rooted ecosystem of providers, organised at whatever scale will keep judgement close to people they know. That is what stewardship means in this sector.

7. What the world has learned while we have argued

While we have argued in the United Kingdom, two countries have travelled, by different roads, to roughly the same place.

In New Zealand, the Enabling Good Lives framework has been worked out by disabled people themselves since around 2011. In 2018 the most radical version of it, Mana Whaikaha, began in the MidCentral region. There are no case managers in the system the way we use that term. There are connectors who walk alongside families. Disabled-led leadership groups hold real authority. Funding is flexible within a plan built around what the person actually wants their life to look like. The system hit a funding crisis in 2024 and was partially rolled back, then partially restored in 2026 after the disabled community refused to accept the retreat. It is a contested story. But in shape and substance it is what I have been describing.

In Australia, the National Disability Insurance Scheme, legislated in 2013, was the largest individualised funding scheme of its kind in the world. It worked in many ways and changed many lives. But it outgrew its projections, because in the country in which it operated there was very little community infrastructure around it. The scheme became, as

it was later put, the only lifeboat. The 2023 review of the scheme proposes a unified ecosystem. Foundational supports for everyone, individual control for those who can use it, and stewardship of the whole by the state. That word, stewardship, is the heart of the design, and it is the word I have been using through this essay.

There is another country worth naming for a different reason. In the Netherlands, since 2006, a home nursing organisation has built a way of working that strips out almost the entire management layer above the front line. Self-directing teams of around twelve qualified nurses, supported by a small central function, hold caseloads of fifty or sixty people each. The model is admired around the world, and pilots have been attempted in this country and elsewhere. None has fully landed here. The reason is not cultural and not technical. The model rests on a workforce of professionally registered, decently paid, autonomous nurses. *The English social care workforce is the opposite of that, paid at or near the statutory floor, professionally unregistered, treated as interchangeable. Self-management at scale cannot be built on a workforce a system has built to be cheap. The model is downstream of valuing the work, and we have not yet valued the work.*

There are others worth naming briefly. In Trieste, from the 1970s onwards, a community mental health system was built that replaced the asylum with a network of local centres attached to ordinary streets and ordinary lives. That model remains the most fully realised example I know of what de-institutionalised mental health support can look like, and it has shaped serious reform in many countries since. In Finland, personal budgets have been adopted nationally as a route to citizenship-led support, drawing on the same international conversation we once helped to lead, although the current Finnish government has reversed that direction and the policy is now being unwound. Even achieved reforms remain politically contingent. In Scotland, which is part of the same political union as England, the Social Care (Self-Directed Support) (Scotland) Act of 2013 set out a statutory right

to choose how social care is delivered, and the main categories of the care workforce there are now professionally registered, as they are in Wales, while England remains the outlier, which is a fact that should embarrass anyone in commissioning here.

A reader looking at both stories from outside might conclude that they are evidence against personalised, citizenship-led models, because both countries have hit cost crises and pulled back. That is the wrong reading. The cost crises came in both cases precisely because the foundation layer was missing under the individual budgets, not because the individual budgets themselves were the problem. Australia's response is to build the foundation. New Zealand's was to defend and restore the original promise. Neither country has abandoned the citizenship-led architecture. Both have moved closer to the layered mix this essay has been describing.

The lesson, for the United Kingdom, is uncomfortable. Both of the first two countries have arrived at the shape we were describing here twenty years ago. Foundational support for everyone, individual control where it can work, stewardship by the state, a plural ecosystem of local providers, citizenship as the frame. These ideas have been present in UK disability and citizenship thinking for decades, but they were never fully built into the commissioning architecture. They were watered down in the 2010s and abandoned in operational terms in the procurement-and-austerity reflex of the early 2020s. The Casey Commission, set up in 2025 and now beginning to set out a National Care Service, is trying to take us toward where the others already are. We are, in this part of the public service, significantly behind where we should be.

8. The culture we have been living inside

Before turning to the specific policy history of the last twenty-five years, I want to take a step back, because the failures the rest of this

essay describes are not really failures of policy alone. They are failures inside a culture that has been making this kind of failure inevitable for some time.

There is a distinction, made by writers a hundred years ago and worth recovering, between what was then called culture, organic, rooted, attached to place and to common purpose, and what was then called civilisation in its late form, individualistic, expansionary, acquisitive, insatiable in its striving, dominated by finance and abstracted from production. The late forms of a civilisation, on that older reading, run on momentum from the cultures that built them, until that momentum runs out.

I am not interested in adopting the larger historical scheme of those writers, and I do not share their cyclical fatalism. But the distinction is useful for our purposes. The last forty years in this country, and across much of the rich world, have been an extraordinary chapter in something those writers would have recognised as the late-civilisation pattern. Production gave ground to finance. Place gave ground to mobility. Vocation gave ground to careers. The expectation that work would be meaningful, properly paid and embedded in community became harder and harder to meet, because the underlying economic logic of the period was extracting from work, not investing in it.

Inside the same period, the kinds of work that could be measured by output and credential rose in status, while the kinds that could only be measured by what they did for a person fell behind. The hands-on, the relational, the embodied, the slow, all of these became, in a society increasingly judged by certificates and league tables, second-class kinds of work, even when they were the work that everything else rested on. That is part of why the dignity owed to the support worker, the nurse on a night shift, the family carer holding the line at home, has been so difficult to translate into anything the surrounding system recognises as serious.

This matters for social care, because the workforce we are now asking to do the most relational, rooted, locally embedded work is the workforce most squeezed by everything in the surrounding culture. A young support worker in 2026 has the entirely reasonable expectation of dignity, growth, autonomy and recognition, and is doing the work inside a system, and a society, that has not really known how to honour any of those things for forty years. The gap is not her fault. It is the gap between what the work asks of us and what the surrounding culture is able to give back. The same condition has been described in different vocabularies across the last century: as the acquisitive society, as the disembedding of the economy from social life, as civilisation outliving culture. They are describing different facets of the same thing.

There is one more thing this section of the essay cannot honestly walk past. A substantial part of the workforce now doing this work in England did not grow up here. In the space of a few years in the early 2020s, the sector recruited internationally at a scale it had never attempted before, and then the door was closed almost as abruptly as it had been opened. The people who came in that window are still here, and many of them will settle, raise families and grow old in the towns where they work. Over the twenty years this essay looks ahead to, they are not a marginal feature of the workforce. They are, on any plausible reading, a large part of who will be holding these lives.

The frame I used earlier for the people we support applies to these colleagues with uncomfortable force. A worker whose right to remain in the country is sponsored by her employer cannot exit in the way a labour market assumes. Leaving a poor employer can mean leaving the country. And a worker who cannot exit thinks carefully before using her voice, because the cost of being heard falls on her visa and not only on her job. What is left, once again, is loyalty without the protections that make loyalty safe. *A system that imports commitment while quietly constraining both exit and voice is running the same extractive architecture this essay has been describing, one layer down, on the people doing the work.* The

registration, the pay floor, the career structure and the respect argued for in this section are not, for this part of the workforce, improvements to a job. They are the conditions under which their citizenship, too, can be held. A sector that asks people to hold the citizenship of others while leaving their own so thinly protected has not understood its own argument.

For commissioning this has a practical edge. We cannot rebuild stability inside the workforce on pay alone, although pay matters. We have to rebuild some of what the surrounding culture has hollowed out, the local roots, the visible purpose, the sense that the work is held by people who know it and respect it, the link between effort and citizenship rather than between effort and shareholder return. That is part of what citizenship means in our part of the public service. It is the part that policy alone cannot deliver, but that commissioning, done with a steward's hand, can begin to protect.

9. Wasted opportunities, and what they have cost

It would be one thing if we had simply never tried. The harder thing about this story is that we have tried, repeatedly, and each time we have stopped just short of the structural change that would have made the attempt land. The architecture that the policy effort kept reaching for could not settle into a culture that was, for forty years, hollowing out the conditions in which it would have needed to live.

In 2003 the practical work of self-directed support and individual budgets began here in earnest. By 2008 the language of personalisation had been formally adopted in policy. By 2014 the Care Act had passed, with a duty to promote individual wellbeing. Each was a window in which the citizenship argument could have settled into the structural architecture of commissioning, and each was only partly used. The personalisation programme largely became a personal-budget allocation programme. The Care Act's wellbeing duty was made fragile by the

austerity decade that followed it. The commissioning architecture itself was never seriously rebuilt around the citizenship frame the rest of the system had formally adopted. The language changed and the architecture did not, and the architecture won. I watched some of this happen from inside the local authorities implementing it, and I was part of the machinery that made some of these choices. The criticism in this section includes its author.

The pattern repeated itself in 2021. A white paper on adult social care promised serious investment in the workforce and in the integration of health and care. Within two years much of the workforce funding had been quietly withdrawn or postponed, and the paper joined a shelf of strategies that had described the right destination without ever building the road.

None of this is to dismiss the people working inside the present programmes. Most of them know the architecture has not changed beneath them, and are doing what they can within it. The argument here is that the architecture itself is what has to change, and that has to happen alongside the policy effort, not after it.

For learning disability and mental health specifically, the pattern is starker and more painful. After the Winterbourne View scandal in 2011 the government promised to move people out of assessment and treatment units by 2014. *The suffering shown in the Panorama programme that exposed the abuse was what set my wife and me on the path to founding, in 2014, the organisation we still run.* The deadline the government had set itself was missed. Transforming Care missed too. Building the Right Support has now missed several of its own targets. Whorlton Hall in 2019 told us we had not learned. Edenfield in 2022 told us again. The number of people stuck in inpatient settings has fallen only modestly across fifteen years of promise. The reason is not lack of community policy intent. It is lack of the local community provision that can hold these people once they come out. And the reason that provision is so thin is, in

significant part, that the commissioning architecture this essay has been describing has not been changed to make it possible.

Running beneath all of this is a quieter, institutional failure. The dispute between the National Health Service and local authorities over Section 117 aftercare, that is, who pays for the support of someone discharged from detention under the Mental Health Act, has, for decades, trapped some of the most vulnerable people in administrative limbo while the two halves of the state argued over the bill. It is a failure not of intention but of architecture, and it remains, in 2026, largely as it was in the 1990s.

We have, then, paid twice for our failure to do the work. Once in money, in the half a billion pounds a year we spend keeping people in hospitals they do not need to be in. And once in lives, in the citizenship those people have not been allowed to live.

10. Diagnosis, demand, and the medical frame

There is a reality I have left aside until now, and any honest argument about commissioning has to face it. The number of people who reach our system with a diagnosis, or with two or three of them, has risen sharply over the last fifteen years. Autism, attention disorders, anxiety, mood disorders, sensory and processing differences. The figures are striking. The parent-reported prevalence of autism in this country has risen by around a quarter in two years. The number of people prescribed medication for attention disorders rose by more than half over three. As I write this, around two hundred thousand people are waiting for an autism referral that has been open more than thirteen weeks, and more than three hundred thousand children are waiting for an assessment for an attention disorder, some of them now into their second year of waiting. Many of these people were always there, missed by an earlier and narrower system, and the wider recognition is a real

gain for them. But the way our system responds to that recognition is the problem.

The other half of the picture is co-occurrence. Adults living with one of these diagnoses very rarely live with only one. The research suggests that more than half, and on some estimates more than nine in ten, of those with an autism diagnosis will at some point in their lives also meet the threshold for at least one other condition, most often an attention disorder, anxiety, or a mood disorder. Where two of these sit together the difficulty in daily life is greater than the sum, and so is the case for support. That is the demand picture commissioners are now sitting with. It is not getting smaller.

We have settled on a response that is largely medical and largely individual. Each diagnosis becomes an entitlement claim, each claim becomes a package of support, each package becomes a line in a budget, and the budgets do not keep up. Commissioners feel this as a wall they cannot get over, and the experience drives a perfectly natural reach for the response I have been describing in this essay, which is to take stability and citizenship seriously rather than to keep building individually procured specialist packages for a population that has not stopped expanding.

There is a deeper point here that I do not want to walk past, because I think it carries the argument of this essay forward. This is not a denial of inherent difficulty, of trauma, of psychosis or of autism as real conditions. It is a refusal to let the diagnostic label do all the explanatory work when structural conditions are doing much of it. We are, increasingly, asking medicine to do work that is not medicine. *Loneliness has become a clinical condition. Social isolation has become a clinical condition. The reasonable distress of a young person watching the world around them become less stable has become a clinical condition. School pressure, the intensification of work, the thinning of community, the absence of belonging, all of these now surface in the consulting room, are given a diagnostic name, and are referred onward for a service.* Some of what we are calling demand is genuine clinical need, and

the more accurate recognition of it is something we should be glad of. Some of it is the diagnostic system metabolising conditions that are properly social, because there is no other open door for them.

There is one more pressure on young people in particular that we should name, because the figures behind the rising demand for support cannot be honestly read without it. The generation that has come of age inside the smartphone, almost universally so in this country, has grown up inside an architecture of constant comparison, intermittent reward and continual attention to a curated version of everyone else's life. Almost every teenager in this country now owns a smartphone, almost all of them are active on social media, and most spend between one and three hours a day there. The evidence has been accumulating, and remains genuinely contested, that this has not been good for them, particularly for young women. *Self-confidence, attention, sleep and wellbeing have moved in the wrong direction. The depression and anxiety that people in their teens, twenties and early thirties are reaching for words to describe are not invented, and they are not, in any simple sense, a matter for medicine alone.* They are an environmental fact about being young in a digital economy. A commissioning response to the rising mental health pressure on this generation has to take that environment seriously, because the cure for an environmental harm is not, in the end, more individual prescription.

This was warned about by writers a generation before us. A society that medicalises the whole of human suffering loses, slowly and then quickly, the cultural and communal capacities to respond to that suffering as suffering rather than as pathology. It is a serious argument. It does not deny illness, and it does not deny that diagnosis can be a gift to people who have spent decades misunderstood. It says only that when the only open door is the medical one, the medical room fills up beyond what any system could resource, and the rest of the building empties.

For commissioning this matters in a very practical way. A system that responds to expanding diagnostic recognition by writing more

individual specialist packages will run out of money long before it runs out of need, and it will deliver, even with the best providers, a thinner and thinner version of what people actually need to live a good life. The exit from that trap is not a refusal to recognise the diagnoses. It is to build the layers that are currently missing under the medical layer. *The foundation of community support, available to everyone, that thickens the place a person lives in. The relationships, the routines, the work, the friendships, the ordinary belonging that holds a life together. The provider layer that brings judgement, continuity and presence close to the person whose diagnoses are, in the end, only part of who they are.*

The traditionalist response, then, is not a refusal to face modern conditions. It is the answer modern conditions are actually asking for. If we are in a generation that is being more accurately identified, more reasonably distressed and more honestly diagnosed than any before it, the system that supports them cannot be a generation of individually procured packages. It has to be a society that knows how to hold its own. Commissioning has a role in rebuilding that. This is the demand pattern the foundation has to absorb without medicalising further.

11. The foundation, and why it has to be commissioned, not granted

I have referred several times in this essay to a foundation underneath the specialist layer of provision, and I want to spend a short section on what I mean by it, because the idea is doing more work in the argument than its passing mentions might suggest, and because there is a reasonable objection to it that needs answering.

The shape of the foundation is this. Below the individually procured packages of support, and below the provider layer doing the relational work, there has to be a layer of provision available to everyone, that thickens the place a person actually lives in. Places where ordinary life is possible. Routines that give a week its shape. Work, even

imperfect work, that gives a person a reason to leave the house and a sense of having contributed. Adult education that is genuinely open to people who do not match the curriculum the system was designed around. Peer support among people who recognise something of themselves in each other. Friendship groups, walking groups, cafés, libraries, community spaces. The things that, when they are present, mean that most people, most of the time, do not need a specialist package, because the conditions of an ordinary life are quietly being held by the place around them.

The reasonable objection is that all of this already exists, in fragments, in this country. Local authorities give grants to voluntary sector organisations. The Lottery funds community work. There is a Care Act duty on local authorities to fund prevention. There are public health grants, social prescribing budgets, charitable trusts, infrastructure organisations, and a sector that has held a great deal of weight on small money for a long time. Some places run Local Area Coordination. Adult education, where it has survived, sits here too. The activity is happening.

The thing that is missing is not the activity. It is the architectural status. What we have are grants. What is needed is commissioning architecture. The difference is real and it matters. Grants are discretionary, and grants are the first thing cut when a budget tightens. The foundation has to be structural, and structurally protected ahead of the specialist spend, not after it. Grants are project-based and time-limited, usually for one to three years. The foundation has to be long-horizon investment in the conditions of ordinary life. Grants sit alongside the commissioning architecture, often in a different team, with a different reporting line, almost as a sidecar. *The foundation has to be inside the commissioning architecture, as its bottom layer, integrated with everything that sits above. Grants are accounted for as money disbursed. The foundation has to be accounted for by whether the place a person lives in has become thicker or thinner.*

The clearest live example of this status change is Australia's foundational supports policy, which is not a grants programme. It is a tier of the system, funded by federal and state governments together, around a defined population, with a defined relationship to the individualised budgets above it. The amounts involved are not small, and they are not contingent on a particular year's surplus. They are a category of commissioning spend, written into legislation. A parallel strand of British thinking, now being articulated under the name of neighbourhood care, is being developed alongside it, and behind both of these sits a longer tradition of community development, asset-based work and relational welfare that has been pushed to the margins of policy for at least a generation.

What I am adding here is the commissioning argument. The foundation has not, in this country, been treated as a commissioning matter at all. It has been treated as something the wider society used to provide for free, and as something the voluntary sector has been quietly asked to hold together since. The argument of this essay is that if the wider society no longer holds these things together on its own, then commissioning has to step in deliberately and fund them. Not as grants on the margin. As the bottom layer of the architecture, funded ahead of need, available to everyone, before anyone arrives at the specialist door.

There are practical consequences. A local authority that takes this seriously stops thinking of community development as a discretionary item to be cut when budgets tighten, and starts treating it as a structural investment in everything that sits above it. The kinds of community organisations that do this work, often very small, often funded precariously, become contractually significant rather than charitably tolerated. The relationship between the individualised budget and the foundation layer becomes part of the commissioning conversation. The people who use the foundation are not service users in the procurement sense. They are citizens of the place, exercising what is theirs.

This is what I have meant, in the rest of the essay, by the community foundation. The operational unit of the foundation is the neighbourhood, at around the four-thousand-person scale where people can actually recognise one another. And the largest part of the foundation is not built by paid services at all. It is built by families, neighbours, friends and circles of trust, by an unpaid relational economy that is overwhelmingly women's and overwhelmingly invisible to public accounting. The role of public commissioning is to support and honour that economy, not to replace it with a thinner paid substitute.

The income architecture that runs alongside the care architecture, the question of how benefits, tax credits and any wider basic-income-shaped reform hold a person's economic citizenship, is a related question this essay does not try to settle. The citizenship argument made here implies the larger answer that others have set out, and the two architectures need each other to land.

The activity is not new. The architectural status is. It is the part of the system the medical and procurement frames left thin, and the part the architecture of the next decade has to put back, not as a sidecar, but as the floor.

12. What is coming

The argument so far has been about what already exists and what would need to be rebuilt inside it. There is a further question, of a different shape, that any honest commissioning argument written now has to face, because the trajectory of the work over the next decade or two is being shaped by a technology that is now beginning to remake almost everything around it.

I cannot write about the next ten years of commissioning without saying something about what I think is coming with it, because the argument I have been making does not stand outside that technology.

A great deal of what passes for knowledge work in our economy, the paperwork, the analysis, the writing of contracts, the monitoring of compliance, the eligibility processing, the production of dashboards and routine strategies, will, plausibly within the next decade or two, be done substantially by machines. This is not a prediction I am offering casually. It is what the people building the technology say, and it is what the machines can already do in narrow domains as I write this in 2026. There is a step beyond, which the field calls artificial general intelligence, a machine able to do what a human can do at the cognitive level. *There is a further step beyond that, at which the technology improves itself faster than humans can follow. Whether or not we reach that further point in any of our lifetimes is a question I do not need to answer here, because the shape of the next decade is already visible to anyone willing to look at it.*

The pattern is one I find easier to describe than to argue with. The work the technology cannot do becomes more valuable, and the work it can do collapses in cost and in status. The bureaucratic core of commissioning is exactly the kind of work the machines absorb first, the tendering, the contract administration, the eligibility processing, the audit, the dashboards. The actual work of care, the noticing on a Tuesday that someone is not themselves, the holding of a hand at three in the morning, the conversation in a hallway that tells you something is drifting, the judgement that comes from years of knowing a person, is precisely the work the machines cannot reach. Embodied attention, sustained relationship, moral presence, the recognition of another person as a person, these are the things that remain, and they are exactly what care is.

AI is already in care, in the form of remote monitoring, medication reminders, fall detection, and the rest of the assistive technology stack that supports the relational work. The argument here is not that AI is absent from care, it is that the relational core of care cannot be automated, however many of the surrounding tasks are.

This has several consequences for the argument I have been making, and they all run in the same direction.

Care, currently treated by every measure as a sector at the edge of the labour market, becomes one of the few large places where paid human work remains. The pay, the status, the way we train, register and retain the people who do it, the seriousness with which the rest of society regards them, are about to become the most important workforce questions in this country, and not by any means only in this country. The architecture around the work is nowhere near ready for what is about to be asked of it.

The procurement core of commissioning, over the same period, disappears. Tendering, contract management, compliance monitoring, eligibility processing, the production of strategies, the audit of paperwork against paperwork, are all absorbed. What is left is the function the technology cannot do, which is stewardship. Holding the ring on citizenship, on the conditions of an ordinary life, on the protection of public money from extraction, on the building of the local care ecosystem, on the workforce, on the next generation of provision. The procurement commissioner fades. The steward grows, or does not. Nothing in the technology compels either outcome.

There is a moral edge here that I want to name plainly, because it is not something the technology will resolve. The same machines that can read drift across a population and warn us of breakdown before it happens can equally be turned onto the workforce as a tool of surveillance. The same back-office collapse that could liberate the small honest provider can also be turned into a managerial gaze that drives every remaining piece of judgement out of the work. The same advocate that helps a family understand their rights can become the polished interface behind which the system hides from the people it is supposed to serve. The same tool, used differently, in service of opposite ends. The choice is moral, not technical, and it will fall, in our sector, very largely to commissioners.

There is a thought I want to put on the page before I move on, because those of us who do this work have a particular reason to think about it. If the technology continues on the trajectory most likely to play out, the question we will be facing within a generation is what societies are actually for, once most of their routine economic activity has been absorbed. The argument I have been making in this essay is, in a quieter way, an early answer to that question. *What survives, and grows in value, is the work of holding human lives together: care, education, hospice, the accompaniment of someone through difficulty, the conditions for ordinary lives. The substance of what this essay has been describing becomes, in the future we are entering, not a corner of the public service but its centre.* That is a remarkable shift in what our sector is about to mean. I do not think the commissioning architecture as it now stands is anywhere near ready for what it is about to be asked to carry.

13. Where commissioning has to go

If the argument so far is right, the work of the next ten years is to rebuild commissioning around citizenship and stability, rather than around procurement and price. That is not a slogan. It has consequences, and I want to set them out plainly enough that someone could begin to act on them.

The first is that the purpose of commissioning shifts. It stops being measured by what it has bought, and how cheaply, and starts being measured by whether the people it is responsible for are living ordinary lives. The inpatient figure becomes the number that judges the work.

The second is that stability becomes the thing you commission. *The conditions for it, continuity, judgement close to the work, leadership presence, learning that stays in the system, psychological safety, professional respect, family partnership and cross-agency working, become contractual matters, funded directly rather than assumed. The signals I have written about elsewhere become the commissioning dashboard.*

The third is that the machinery shifts with it. The block contract, the framework, the fifteen-minute visit, the cost-and-volume schedule, all of which are the late inheritance of new public management, give way to a mix that has three layers. A foundation of community support funded for everyone, of the kind Australia is now legislating. Individual control through individual service funds or direct payments for those who can use it, with families, advocates and circles of trust around those who cannot. And a properly regulated provider layer of organisations designed for closeness to the person, of any legal form, often small and medium and rooted in place, or larger but federated into locally accountable units, doing the actual relational work.

And the personal budgets, individual service funds and direct payments that already exist on the books in England are made to have teeth. The current versions of them are weak, controlled too often by the commissioner's preferred provider list, slow to switch, sometimes a procurement function with a different name on the door. The point of these instruments was authorship over a life. That is what they have to become again.

The fourth is that quality, not legal form, becomes the regulated variable. Transparency on ownership, related-party transactions, profit extraction and leverage becomes the norm for any organisation receiving public money. The large national charity loses the halo it has been wearing while taking two years to set up someone's individual service fund. The private-equity chain loses the contract because the money is leaving the country. Not every large provider fits this picture. Some large providers, of every legal form, do this work well, employ thousands of people whom no smaller organisation could employ, and reinvest more than they extract. The test is what the organisation does, not its size. What is favoured is what stays close, and reinvests in its own people and its own place.

The regulator's role changes with this. A regulator whose existing inspection regime is built around the documented features of registered

services has to learn to read what the eight signals describe and what the commissioning architecture now requires. That is a substantial shift, and it has only just begun in the most recent CQC framework. Without a regulator able to assess the conditions for stability and citizenship rather than only the documented compliance with the conditions of registration, the architecture of the next decade cannot land. *The work of rebuilding commissioning has to happen alongside the rebuilding of regulation. The two are part of the same project.*

The fifth, and the one least obvious until you have lived inside it, is that the workforce becomes the thing you actually commission. England registers its care workers, as Scotland and Wales already do. The pay floor moves above the survival floor. Career structure becomes real. Commissioning contracts begin to specify the leading indicators of quality, the workforce conditions of the provider, rather than only the lagging ones, the outcomes that follow from them.

The sixth is co-production with real authority. Disabled people, families, frontline workers and practitioner-founders sit in the commissioning room, not as people consulted after the decision is drafted, and not only as advisors. Real authority here means decisions can be lost in the room rather than rubber-stamped after it, on the model of the disabled-led leadership groups New Zealand has built into Mana Whaikaha, and anything less is consultation theatre. Without their voices, the historical pattern I described earlier in the essay quietly reasserts itself in commissioning, and the decisions drift away from the people who know the work. The system stops being something done to people with their consent, and becomes something they author with those who hold the public money.

The seventh is that commissioning builds a community foundation, not only a crisis response. The diagnostic and procurement frames have left thin the underlayer that holds ordinary life together: places where belonging is possible, where a relationship to work, learning and friendship is part of what is funded, where the structural conditions of

distress are met by structural responses, not only by clinical ones. That underlayer is funded for everyone, ahead of need, as part of the same architecture.

The eighth is that the artificial line between health and social care funding, the line that has trapped people in inpatient settings for years while the two halves of the state argued over Section 117 aftercare, is dissolved at the local level. The money for the health and the care of the same person comes from one pot, accountable to a single body, around a defined population of citizens. This is not the pooling that has been tried and failed in this country since the late 1990s, through section 75 agreements, the Better Care Fund and the integrated care board structures. Those previous attempts pooled the money at the level of the institutions, around the buildings, the budget lines and the contracts. The version this essay calls for pools the money around the person and the place, with statutory backing, in a single accountable body. That is the version that has not yet been tried in this country. It is the version the Australian foundational supports policy now codifies, and it is the version the Casey Commission will eventually have to recommend if its work is to land. This will be called radical when it is first proposed, and so it should be, because it is. The alternative is the continuing scandal of someone whose life is held in administrative limbo while the state decides who pays for them.

The ninth is what I have come to think of as the entrepreneurial duty. The state, through local authorities working with regional partners, runs a deliberate fund and a support function for new and growing provision. The machinery exists for general business in this country, in start-up loans, the British Business Bank, and the social investment work of Big Society Capital and Power to Change. None of it has been seriously pointed at care. It should be.

By entrepreneurial I mean the full range of forms, the for-profit start-up that reinvests in its place, the social enterprise, the cooperative, the community business, the charity built from scratch by people who

have done the work themselves. The legal form is secondary. What matters is that people with the right intent, who know the work, can get the capital and the support to build.

For every restaurant that opens on a high street, most close within two years, and we plan for that without grief. Care providers are not so different. If we want a living local ecosystem, we have to seed new entrants steadily, so that when some inevitably fail, others are ready to grow into the space. Right now we starve the pipeline at one end and describe the scarcity at the other as if it were a fact of nature.

What I am calling the entrepreneurial duty sits alongside the parallel work of the Neighbourhood Democracy Movement, which is a serious attempt to put the locus of decision at the lowest level a decision can sensibly be made. *The democratic frame and the entrepreneurial frame are not in competition. They need each other. A neighbourhood that has the authority to decide what kind of provision it needs, but no instrument for bringing it into being, can debate without building. An entrepreneurial fund without local democratic governance is technocratic and easily captured. The two together describe what it would take to renew local care, by giving citizens both the authority and the resource to build what their community needs, on the terms their community can trust.*

The tenth is that the role of commissioner itself becomes stewardship. The stewardship of a local care ecosystem is what the role has always needed to be, in any technology future. The technology described in the previous section accelerates that shift, by absorbing the procurement core, but the stewardship case stands on its own and does not depend on the timing of the machines.

The eleventh is that the duty to seed new provision is matched by a duty to hold the person's relationships steady when old provision fails. On the argument of this essay, the catastrophe in a provider's collapse is not the contract ending; it is the relationships ending. A commissioning function serious about stability plans provider exit the way it plans provider entry, with continuity of the team around the person, not just

continuity of a service with new branding. The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) does some of this accidentally; serious commissioning would do it deliberately.

14. The duty

What this essay has been describing, from different angles, is in the end the working out of a duty that has shifted, and that few of us have been honest enough to name out loud.

Citizenship is not declared, it is built, and it is usually built against the convenience of the powerful. It can be claimed, sometimes, by people on their own account, when their voices have been ignored rather than absent. *The people I have written about in this essay, and in the essay that came before it, are not in that position. They often cannot fight on their own account. They cannot stand up and say what they need. They cannot read a contract. They cannot tell us afterwards whether the support was good or whether they were simply kept quiet. So the duty moves. It moves to the people who commission, and to the people who provide, and to those of us, in any role, who have been entrusted with public money and with public lives.* Without us, they have no voice. That is the most serious responsibility any of us carry, and I do not think there is a more serious one anywhere in the public service of any country that calls itself democratic.

The work of the next decade is to rebuild the part of the system that decides whether that responsibility is honoured. Not the part that delivers the support, though that matters. The part that decides whether the support that is delivered can be good, and stable, and close, and ours. I have tried, in this essay, to describe that part as honestly as I can, and to say what it would look like if we let citizenship be the question, and stability the condition, and the citizen the centre of the work.

That is the duty. And that, still, remains the work.

Appendix: Eleven principles for the future of commissioning

The principles below are not a new ideology. They are a practical architecture for holding attention where commissioning keeps losing it. They distil the argument of the essay into a usable form. They are not a checklist. They are conditions, like the signals in the companion paper, that work together or fall together.

1. Citizenship is the purpose.
The point of commissioning is not to buy services but to secure for each person the conditions of an ordinary life. A commissioning function judged by what it has purchased, and how cheaply, is missing the point. One judged by whether the people it is responsible for are living ordinary lives in their own homes has found it.

2. Stability is the condition.
Stability is not one good idea among many. It is the condition that makes the others real. A personal budget without stability does not land in a person's life. A contract without stability does not survive the next round of turnover. Continuity, judgement close to the work, leadership presence, learning that stays, psychological safety, professional respect, family partnership, and cross-agency working are what is being commissioned for, before anything else.

3. A mix, not a market.
The system has three layers. A foundation of community support funded for everyone. Individual control through individual service funds and direct payments for those who can use it, with families and circles of trust around those who cannot. And a properly regulated provider layer of organisations designed for closeness to the person, of any legal form, often small and medium and rooted in place, or larger but federated into locally accountable units. No single layer is the answer. The mix is.

4. Quality, not legal form, is what is regulated.
A provider is judged by what it does for the people it supports, not by its tax status. Transparency on ownership, related-party transactions, profit extraction and leverage becomes the norm for any organisation receiving public money. The large national charity and the private-equity chain are held to the same test, and both can fail it. The regulator's role shifts with this, from inspecting documented compliance with the conditions of registration to assessing the conditions for stability and citizenship.

5. The workforce is what you actually commission.
Stability, retention and the conditions for judgement are commissioned for directly. Professional registration, a real pay floor, career structure, and the leading indicators of workforce health become contractual matters. The eight signals of system stability become the commissioning dashboard.

6. Co-production with real authority.
Disabled people, families, frontline workers and practitioner-founders sit in the commissioning room with real authority, not as people consulted after the decision is drafted, and not only as advisors. Real authority means decisions can be lost in the room, not rubber-stamped after it, on the model of the disabled-led leadership groups New Zealand has built into Mana Whaikaha. Anything less is consultation theatre. Systems that lose the voices of those closest to the work hollow out. The system stops being something done to people with their consent, and becomes something they author with those who hold the public money.

7. A community foundation, not only a crisis response.
Commissioning for a generation of expanding diagnostic recognition and rising demand cannot rely on more and more individually procured specialist packages. It has to build the underlayer the medical and procurement frames have left thin: places where ordinary life is

possible, where belonging can be found, where a relationship to work, learning and friendship is part of what is funded, and where the structural conditions of distress are met by structural responses, not only by clinical ones.

8. Health and care funding meet at one place.
The artificial line between the National Health Service and the social care system, the line that has trapped people in administrative limbo for decades, is dissolved at the local level. The money for the health and the care of the same person comes from one pot, accountable to a single body, around a defined population of citizens rather than around the institutions. That is the level at which previous pooling attempts have not landed, and it is what would make this version different. This is radical, and it is necessary. Unlike the other ten principles, this one cannot be delivered locally on its own and requires national statute. The other ten can begin under current law and current budgets while it is fought for, and should not be deferred while it is.

9. The entrepreneurial duty.
The state, through local authorities working with regional partners, actively seeds new provision. A deliberate fund and a support function for new and growing providers, modelled on the start-up and social investment instruments already used in general business. The pipeline is built so that when some providers inevitably fail, others are ready to grow into the space. The entrepreneurial frame covers private, social, cooperative and charitable forms alike. What matters is who is seeded, on what terms, and to what end. This sits alongside the work of neighbourhood democracy, not apart from it.

10. The commissioner becomes a steward.
The stewardship of a local care ecosystem, holding the ring on rights, on citizenship, on the protection of public money from extraction, on the workforce, and on the next generation of provision, is what commissioning has always needed to be. The technology accelerates

that shift by absorbing the transactional core, the tendering, contract administration, compliance monitoring and eligibility processing that have crowded the stewardship work out. But the stewardship case stands regardless of when the machines arrive.

11. Commission for graceful failure.
The duty to seed new provision is matched by a duty to hold the person's relationships steady when old provision fails. On the argument of this essay, the catastrophe in a provider's collapse is not the contract ending; it is the relationships ending. A commissioning function serious about stability plans provider exit the way it plans provider entry, with continuity of the team around the person, not just continuity of a service with new branding. TUPE does some of this accidentally; serious commissioning would do it deliberately.

References and influences

These people and resources shaped how this work developed in practice. I list them here for anyone who wants to see the roots of the ideas.

F. H. Bradley – morality and identity constituted by one's station and its duties, not by abstract individual choice.

R. H. Tawney – the distinction between acquisition and function: institutions justified by the purpose they serve, not by what they extract.

Richard Sennett – the corrosion of character under flexible capitalism, and the conditions for sustained meaningful work.

Michael Sandel – the tyranny of merit: how elevating credentialled and measurable work hollows out the status of relational and embodied work.

Albert Hirschman – exit, voice and loyalty: how markets discipline through the freedom to leave, and what is missing when that freedom is absent.

Simon Duffy – citizenship as authorship over a life, the keys to an ordinary life, personalised integration, neighbourhood democracy, and neighbourhoods of care.

Catherine Needham – the academic account of how personalisation became a story the system told while the architecture stayed the same.

Jon Glasby – the evidence record on personal budgets and direct payments, and the gap between the policy and its implementation.

John O'Brien and Connie Lyle O'Brien – person-centred planning and the five valued experiences, the disability-practice tradition behind the argument here.

Jim Mansell – the Mansell Reports of 1993 and 2007, and the active-support tradition in community provision for people with learning disabilities.

Julie Beadle-Brown – the evaluation of community supports for people with learning disabilities, and the implementation of person-centred active support.

Irene Tuffrey-Wijne – mortality reviews and reasonable adjustments: the academic case for systemic rather than individual causes of poor outcomes for people with learning disabilities.

Lauren Ramsey and colleagues – the qualitative integrative analysis of systemic safety inequities for people with learning disabilities in English health and social care.

Karl Polanyi – when markets organise everything, the conditions for an ordinary life are pushed aside.

Franco Basaglia – the dismantling of the asylum and the building of community mental health in Trieste.

Elinor Ostrom – decisions held at the lowest level at which they can sensibly be made; the case for plural over central governance.

Mariana Mazzucato – the state as a market-shaper, not only a market-fixer.

Hilary Cottam – relational, community-rooted welfare, and the limits of transactional services.

D.W. Winnicott, John Bowlby and Mary Ainsworth – the holding environment and attachment theory: stability as the psychological precondition for development and ordinary life.

Jeannie Haggerty and colleagues – the multidisciplinary review of continuity of care, naming its informational, management and relational dimensions.

Ivan Illich – the medicalisation of human suffering, and the loss of communal capacities to respond to it as suffering rather than pathology.

G. Venkataswamy and the Aravind Eye Care System – purpose-driven care built on discipline, scale and compassion.

James Heskett, W. Earl Sasser and Leonard Schlesinger – the service profit chain: how staff conditions determine what users experience.

Amy Edmondson – psychological safety as the strongest predictor of team performance.

Stuart Russell – the trajectory of artificial intelligence and the problem of control.

Daniel Susskind – what the next decades of automation are likely to do to paid human work.

Jonathan Haidt – the structural pressure of constant comparison and intermittent reward on the mental health of young people.

Bruce Bonyhady – architect of the Australian National Disability Insurance Scheme and its review, and the source of the language of stewardship in care.

Luke Kemp – the historical pattern by which systems hollow out when those closest to the work lose their voice.

The Enabling Good Lives leadership groups, New Zealand – the working example of disabled-led system reform.

Mencap and Learning Disability Today – continuing scrutiny of institutional care in England.

NHS England Digital – official statistics on people with a learning disability and autistic people in mental health hospitals.

United Nations Convention on the Rights of Persons with Disabilities (2006) – the international rights framework the citizenship argument operates within.

The Casey Commission on Adult Social Care – the present attempt to set out a National Care Service for England.

Author note

Vinesh Kumar founded iDirect, with his wife Subha Kumar, in 2014. The organisation supports people with learning disabilities and long-term mental health conditions in the South West of England. The reflections in this paper arise from building and correcting iDirect over a decade, and before that from years spent as a consultant inside the local authorities, provider organisations and primary care implementing the policies the essay describes.

Vinesh Kumar holds a financial and professional interest in the architecture of provision the essay advocates, as the founder of a small care provider operating within publicly funded health and social care. The argument has been made as honestly as it can be made within that interest.

The essay is written for those who commission and provide social care, and for the wider conversation about its reform. An easy-read version, designed and produced by Clare Tarling, is published alongside it, so the people whose lives the essay is about can read it as readily as those who commission their support. Audio and British Sign Language versions are recognised as a further step.

June 2026