The conditions for an ordinary life

A short version of an essay on commissioning, citizenship, and the duty that has moved.

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WHY THIS MATTERS

There are around two thousand one hundred people with learning disabilities or autism living in mental health hospitals in England as I write this. Many have been there for years. Almost half could be in the community if the support around them held. Each placement costs the public purse around a quarter of a million pounds a year. We pay for the failure to commission stability, every day, at the most expensive possible price, and we describe the bill as inevitable.

That is the visible failure. Beneath it sits a less visible one. The community provision that 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 many thousands of communities lives held by very little.

This is a short version of a longer essay on commissioning, citizenship and the duty that has moved. The ground is learning disabilities and serious mental health. The architectural argument travels wider, into older people's care and adult social care generally, but the specific evidence is from where I have worked. The essay does not attempt a full account of race, ethnicity and migration, though the position of the overseas workforce is faced directly in the longer version. That remaining limit of scope is named here so the reader knows.

The argument

The work of commissioning is not, fundamentally, to buy services efficiently. It is to secure for each citizen the conditions of an ordinary life. That is a citizenship question, not a procurement question. For the people I write about, who often cannot exercise consumer choice, cannot exit a poor provider, and cannot voice the complaint, citizenship has to be held by someone they trust. The most important condition that holds it is stability: the continuity of relationships, judgement close to the work, leadership presence, learning that stays, psychological safety, professional respect, family partnership and cross-agency working. These are not soft preferences. They decide whether a small change becomes a calm adjustment or an emergency placement. The deeper psychological tradition has been pointing at the same conditions for nearly a century, in the holding-environment and attachment-theory work of mid-twentieth-century developmental psychology. What I call stability in care is, at its deepest level, the holding environment translated to adulthood and to public systems.

We have built, over thirty-five years, a commissioning system whose internal logic is procurement. 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. The architecture has consequences we are paying for. A workforce paid at the floor of the labour market and treated as interchangeable. Providers consolidated upward into larger, often distant chains who specialise in winning bids and managing compliance, not all of them, since some large providers do this work well at scale of any legal form, but enough of them to bend the system. A foundation of community provision treated as discretionary grants rather than as the floor under everything else. Personal budgets and individual service funds that were meant to be authorship over a life were reduced in practice to a procurement function with a different name on the door.

Two countries have arrived, by different roads, at the place we were describing here twenty years ago. New Zealand's Enabling Good Lives framework gives disabled-led leadership groups real authority and flexible funding for an ordinary life. Australia's Foundational Supports policy is rebuilding the community layer that the individualised insurance scheme could not provide on its own. Both have arrived at the same shape. A foundation of community support funded for everyone, individual control where it can work, stewardship of the whole by the state, and a plural ecosystem of small and medium providers. The cost crises both countries have hit are not evidence against citizenship-led models. They are evidence that those models cannot work without the foundation layer underneath. These ideas have been present in UK disability and citizenship thinking for decades but were never fully built into the commissioning architecture. We are significantly behind where we should be on their implementation.

Two political poles tempt us when systems fail at this scale. Full nationalisation and full marketisation. Both, if enacted, would fail in the same way because both centralise power and push decisions away from the person. The state monolith and the private-equity chain are the same shape, viewed from inside the home of someone whose support has broken down. The historical record of why complex institutions collapse shows the same pattern. They collapse from within when those closest to the work lose their voice and power concentrates upward. Our sector is showing every line of that pattern in slow motion.

The economic case is the one commissioner actually have to make. Funding the conditions for stability is significantly cheaper than not funding them. The savings show up in budgets the original commissioner does not control, which is the financial trap we are inside. The methodological objection that the evidence for this is thin in a narrow Treasury sense deserves a direct answer. Thirty-five years of narrowly framed evidence-based commissioning have not prevented the inpatient figure with which this essay began, and the system we have

built on that methodology is the strongest argument against it. There is, however, real work that can begin now with the money already in the system. Longer contracts. Spending shifted from monitoring into development. Contracts that specify the leading indicators of quality, workforce stability and retention, rather than only the lagging ones. Budgets pooled at the level of a place. Refusing further contracts to providers whose money is leaving the country. None of this closes a council's existing funding gap. It is work that buys us time without buying us cost while we wait for the deeper reform. The wait for national reform is, for the people in our care, an expensive wait.

The culture that produced this failure is older than the policy. Forty years of speculative finance, the rise of credentialled and measurable work over relational and embodied work, the thinning of place and community have together hollowed out the conditions a young support worker needs to do this work well and be honoured for it. The workforce question is, in the end, a cultural question about what we value as work. Policy alone cannot answer it. And a workforce now substantially recruited from overseas, whose right to remain is sponsored by the employer, holds neither exit nor safe voice. That is the same extractive architecture, one layer down, on the people doing the work.

The demand picture is rising and will continue to. Diagnoses of autism, attention disorders, anxiety and mood disorders have grown sharply, and more than half of those with one diagnosis live with two or more. We have settled on a response that is largely medical and largely individual, and the budgets cannot hold. The exit from that trap is not a refusal of the diagnoses. It is to build the layers currently missing beneath the medical layer. A community foundation, available to everyone, that thickens the place a person lives in. The work, the friendships, the routines, the ordinary belonging that holds a life together.

The foundation has, in this country, been treated as voluntary sector grants on the margin rather than as commissioning architecture at the floor. The activity is happening. The architectural status is what has to change. Grants are discretionary and cut first when budgets tighten. The foundation must be structural and protected ahead of specialist spend. Grants sit as a sidecar to the commissioning system. The foundation must sit inside it as its bottom layer. The operational unit is the neighbourhood, around the four-thousand-person scale at which people actually recognise each other. The largest part of the foundation, it must be said, 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 thinly paid substitute.

There is one 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 is being shaped by a technology that is now beginning to remake almost everything around it. Within the next decade or two, plausibly, most rules-based knowledge work will be done by machines. The bureaucratic core of commissioning, tendering and contract management and compliance monitoring will be among the first absorbed. The care itself, the noticing on a Tuesday that someone is not themselves, the holding of a hand at three in the morning, and the judgement that comes from years of knowing a person, is what the machines cannot reach. AI is already in care in the form of assistive technology that supports the relational work; the argument here is that the relational core itself cannot be automated, however many of the surrounding tasks are. Care is about to become one of the largest places where paid human work remains, and the workforce question and the cultural question are about to become the most important political questions we face.

The duty

Citizenship is not declared; it is built, and it is usually built against the convenience of the powerful. The people I write about often cannot fight on their own account, cannot read a contract, 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 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 delivered can be good, and stable, and close, and ours. The principles below distil what that means in practice.

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 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 become 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. 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.

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