UNIVERSITY OF LIVERPOOL

Heseltine Institute for Public Policy, Practice and Place

INNOVATIONS IN PUBLIC SERVICE DESIGN AND DELIVERY

INSIGHTS FROM THE HESELTINE INSTITUTE POLICY BRIEFINGS

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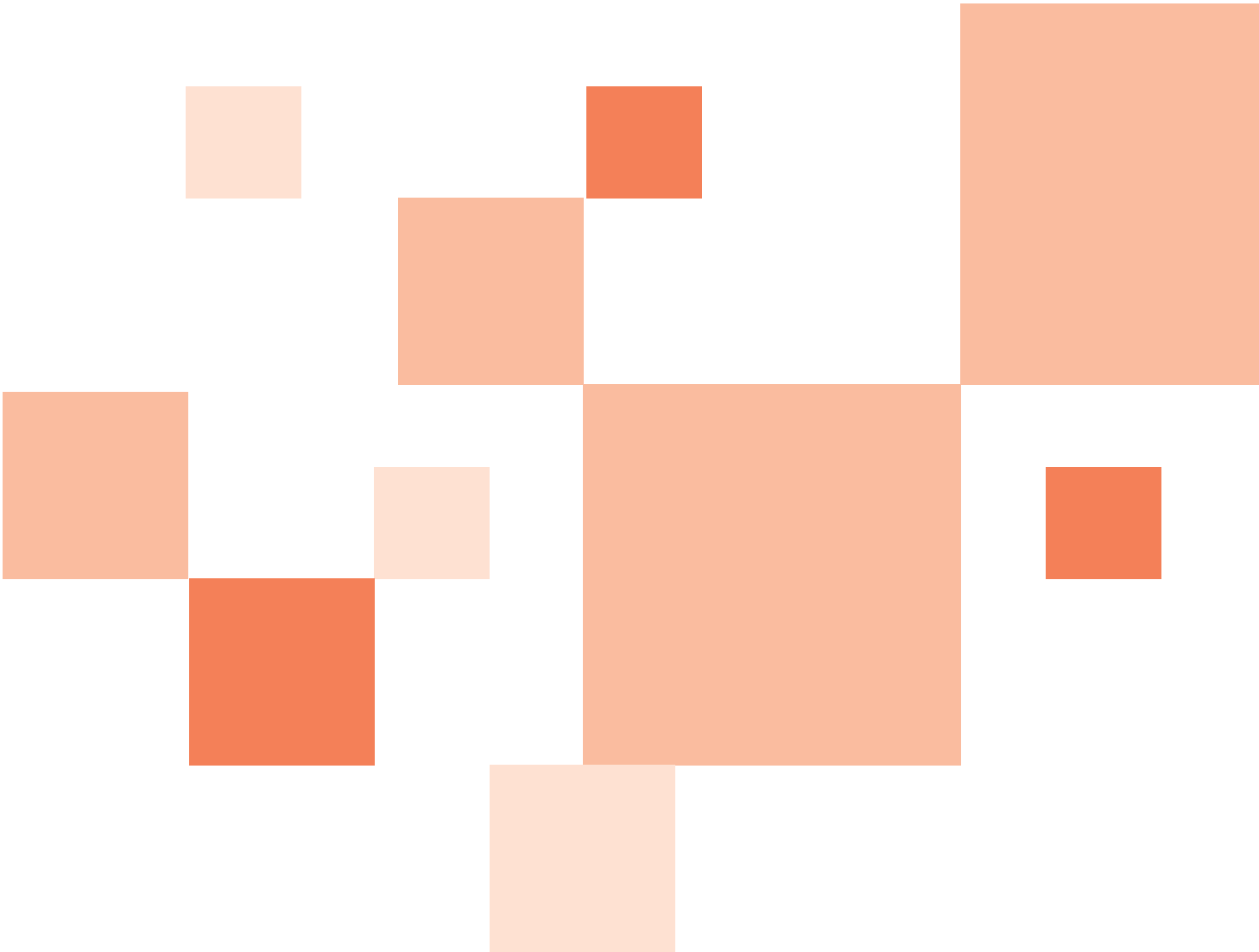

Introduction

Over recent years, combined and local authorities in England have demonstrated an array of innovative approaches to the design and delivery of public services. While the impact on services wrought by austerity has been devastating, innovations are aligning services more closely with communities, helping to develop skills within the public sector workforce, and using technology to save time and money. Devolution in England provides the opportunity for combined authorities to integrate public services across wider geographies, with the English Devolution White Paper proposing greater responsibilities for Mayoral Combined Authorities in areas such as public health, housing and skills.

However, public services in the UK are under unprecedented pressure. An ageing population is placing increased demands on social care and the NHS. The needs of many people accessing services are increasingly complex, with intersecting challenges as a result of ill health, unemployment or low wages and poor quality housing. Weak economic growth over the last 15 years has reduced tax revenues and constrained public spending. The Covid-19 pandemic created backlogs in healthcare and the justice system, and there is **growing evidence** that it will continue to impact the education outcomes of children and teenagers well into the 2030s.

Within this daunting context, the UK government is rolling out a series of reforms to the operation of public services. In his **March 2025 speech on "reforming the state"**, the Prime Minister announced several proposed changes, including the removal of quangos such as NHS England, increasing the use of technology and data sharing initiatives, and improving civil service performance. Government has also committed to **a 'test and learn' approach** to tackling the UK's biggest public sector challenges, learning from work undertaken in places like Liverpool and Manchester.

This embrace of new approaches is exemplified by the **Office for Public Service Innovation** (OPSI). Led by Liverpool City Region Combined Authority and recommended by the **Liverpool Strategic Futures Advisory Panel** in 2024, the OPSI aims to:

> "**Convene, support and enable partners** - including Liverpool City Region's six local authorities, the NHS, housing associations, emergency services, universities, businesses, grassroots organisations and communities – to design and deliver innovative solutions desperately needed to break long-standing, deep-rooted deprivation."

These aims will be delivered across several themes:

- Using data more effectively and using AI for public good: improving information sharing and governance to deliver more holistic public services to tackle poverty, poor health and lack of opportunity.
- Workforce development: improving skills and offering routes for progression for staff working in frontline service delivery.
- Focusing on prevention: emphasising early interventions that deliver better value for money and prevent longer-term declines in health, economic conditions and housing.
- Test, learn and grow: developing new approaches, tracking their results and learning from both success and failure.
- Develop trust: working with communities to improve the reach and effectiveness of public services.

Many of these principles are emphasised in this collection of insights from the Heseltine Institute policy briefings. It features pieces published over the last five years and illustrates many of the challenges public services face, and the ways local and regional leaders are tackling them to improve outcomes. In the context of unprecedented pressures on the public sector, these briefings highlight three questions on how public service innovation can help to ensure resilience, make services more responsive to citizens and improve their effectiveness.

How can innovation help public services become more resilient?

Few events in post-war history have tested the resilience of public services in the UK like the Covid-19 pandemic. Defined by UK Government as the "ability to absorb and adapt in a changing environment", resilience is **increasingly used as a concept** to understand how public sector organisations achieve intended outcomes through uncertainty, disruption and change. As Dr Ray Kent (formerly Chief Operating Officer at the University of Liverpool's Pandemic Institute) and Dr Paul Atkinson (Lecturer at the Institute of Population Health at the University of Liverpool) write in their 2023 briefing, building resilience in the healthcare system will be crucial to ensuring an effective response to any future endemic infectious diseases. They argue that resilience can be secured by focusing on institutions and relationships

within places: "a holistic approach to disease detection, response and containment…bringing together at sub-national level, groups of civic actors, healthcare practitioners, academic experts and representatives from civil society to form pandemic prevention, preparedness and response taskforces."

The pandemic also upended our relationship with the workplace, prompting a dramatic and sustained increase in hybrid and remote working. These changes have tested the resilience of many employers and employees, while providing opportunities for others. In a briefing published in February 2021, Professor Clare Rigg (Professor of Post-experience Management Education at Lancaster University Management School), Jennifer Knights (Specialist Research Lead for NHS Education for Scotland) and Kennedy Myers (former Research Assistant at University of Liverpool Management School) discuss this rapid transition to online working in the public sector. Remote and hybrid working practices are now common across for staff in public service roles in a way unimaginable just a few years ago. The authors highlight the need for public service leaders operating in this context to display digital literacy, emotional intelligence and empathy, while proposing a series of practical recommendations for leaders navigating this new working world. Those capable of deploying these forms of leadership will, the authors argue, contribute to the development of more resilient organisations. Five years on from the start of the pandemic, the lessons from these briefings remain relevant as the public sector negotiates the ongoing **'polycrisis'**, exemplified by increasing global instability and uncertainty.

How can innovation make public services more responsive to citizens?

Trust in **public institutions in the UK is generally strong**. However, OECD research suggests maintaining this trust is dependent on citizen perceptions that they are **able to 'have their say' in how services are run**. In their November 2021 briefing, Dr Clarissa Giebel (Senior Research Fellow in the Institute of Population Health at the University of Liverpool) and Dr Kerry Hanna (Lecturer and Postdoctoral Researcher at the University of Liverpool, and Director of Research at the British and Irish Orthoptic Society) highlight the dangers of disengagement from staff and families in the social care sector, such as failures to acknowledge the preferences of service users. The briefing reveals the extent to which the Covid-19 pandemic shone a light on problems in care homes in the UK resulting from poor levels of pay, inadequate staff training and few opportunities for career development, contributing to high levels of stress and low morale within the social care workforce. The authors call for new national-level guidance to develop a more inclusive approach to care home provision and staffing, highlighting the need for public services to engage frontline staff, service users and families, through the involvement of these groups in service design via forums such as **patient, carer, charity and citizen networks**.

One such inclusive method for treating physical and mental health conditions is social prescribing – the referral of people to community-based social, cultural and environmental activities aimed at strengthening wellbeing. Dr Koen Bartels (Associate Professor in Public Administration and Policy at the Department of Public Administration and Policy, University of Birmingham, and Heseltine Institute Visiting Fellow) sets out the elements of an 'asset-based ecosystem' to support social prescribing, based on research in the Wirral. The briefing argues that by "building relationships of mutual understanding, trust and support between stakeholders", social prescribing is an innovative approach that can provide more equitable and sustainable routes to supporting health and wellbeing. Social prescribing is a key element of Wirral Council's approach to improving public health in the district, exemplified by programmes such as **Flourish Wellbeing Hub**. As public finances in the UK remain constrained, preventative approaches to service delivery that save money in the longer term will be increasingly important. As social prescribing illustrates, it is particularly important that preventative approaches are delivered in ways that engage and include citizens.

How can innovation in public services be harnessed by local and regional institutions?

Few policy areas are as ripe for innovation as housing. The recent **Competition & Markets Authority (CMA) report** into housebuilding found that 40% of new homes are built by the 11 largest developers in Great Britain. Traditional constructions dominate the housing market, with bricks the predominant building material for new homes in the UK, and the CMA reporting "levels of innovation in the industry area lower than we might expect in a dynamic, well-functioning market". One potential part of the solution to this challenge is to diversify routes into housebuilding. As Dr Philippa Hughes (Marie Curie Postdoctoral Research Fellow at the UNESCO Housing

Chair, Universitat Rovira I Virgilli in Tarragona) argues, community-led housing – including models such as community land trusts, cooperatives and cohousing – could contribute to meeting the Labour government's ambitious housebuilding targets. The briefing recommends a series of reforms to scale up community-led housing, highlighting the potential of bottom-up initiatives to contribute to tackling public policy challenges such as meeting demand for new homes.

Improving the energy efficiency of existing homes is a similarly long-standing challenge for local authorities. With residential buildings contributing around 15 per cent of overall greenhouse gas emissions, decarbonising housing will be central to achieving net zero by 2050. In his briefing, Dr Wayne Shand (independent researcher and Visiting Fellow at the Heseltine Institute), uses evidence from a successful programme of social housing retrofit in the London Borough of Camden to set out a series of reforms to the sector which could help ramp up delivery, create jobs and ensure communities benefit from vital retrofit programmes across UK cities and towns over the coming decades.

This collection of policy briefings illustrates the wide variety of innovative approaches possible in public service design and delivery. It also demonstrates the necessity of avoiding a top down, one size fits all remodelling of how public services operate. In a December 2024 speech, Cabinet Minister Pat McFadden pledged to bring a 'start up mindset' to government, offering to support departments and local leaders to 'test and learn'. This will mean avoiding the temptation to implement 'stock' frameworks for organising service delivery such as New Public Management, or an overreliance on technology to drive efficiency. Instead, local and combined authorities should be enabled to design and deliver services in ways appropriate for the communities they serve.

Mann Island, Liverpool

Dr Ray Kent and Dr Paul Anderson

Pandemic-proof cities: creating resilient healthcare systems to prevent, prepare for and respond to future health shocks

Key takeaways

1. An effective response to emerging and endemic infectious disease lies in creating and maintaining a resilient public health-care system.
2. Building such a system on the scale of a city or city-region necessitates that all of the key actors come together in 'peacetime' to design and rehearse an integrated, multi-partner response to emerging infections that can be activated during 'wartime'.
3. Resilience planning requires the participation of community representatives as well as healthcare experts, to explore ways of integrating the unique knowledge possessed by each set of actors.
4. Regular stress-testing and updating of resilience plans is essential. This can be carried out by running simulation exercises at a sub-national level and encouraging the sharing of knowledge between cities and city-regions.
5. Local resilience plans should be benchmarked against international good practice, for example through the use of a resilience index consisting of key indicators.

1. The challenge of infectious disease threats

The COVID-19 pandemic has resulted in at least 7.7 million reported deaths and 18.6 million estimated deaths worldwide, of which the UK accounts for some 228,000 deaths or 340 deaths per 100,000 head of population (IHME, 2023; UK Coronavirus Dashboard, 2023). Whilst officially the crisis is over – on 5 May 2023 the World Health Organisation (WHO) declared "with great hope" an end to the public health emergency – it is clear that the socio-economic shocks from this pandemic will continue to reverberate around the world for many years to come. COVID-19 has been described as "both a profound tragedy and a massive global failure [to prepare and respond] at multiple levels" (Sachs *et al.,* 2022).

According to Dr Tedros Adhanom Ghebreyesus, WHO Director-General, the pandemic has **"exposed political fault lines***, within and between nations … [and]* **eroded trust** *between people, governments and institutions,* **fuelled by a torrent of mis- and disinformation**." The critical policy challenge is to learn from these failings so as to forestall the next pandemic.

This is more easily said than done, not least because preventing, preparing for, and responding to epidemics and pandemics is costly. Thus, the UK Government is estimated to have spent between £310 billion and £410 billion on public health measures during COVID-19, equivalent to between £4,600 and £6,100 per head of population (House of Commons, 2023). Globally the cost of this pandemic is estimated to be between £6.6 trillion and £12.9 trillion (WHO, 2020). Alongside the eye-watering costs, there is a pervasive sense of (post-) pandemic fatigue that blunts our willingness to mobilise now against what is undoubtedly coming – 'Disease X', an as-yet unknown infectious disease with epidemic potential, or perhaps a re-emerging pathogen (see WHO, 2022). In an era of polycrisis where there are numerous important issues

lining up to be addressed – wars, famine, repression, modern slavery, migration, climate change – which of these should governments prioritise?

It is natural to feel overwhelmed but that does not mean that doing nothing is an option. Outbreaks of novel viruses have occurred on an irregular basis over the past 100 years but disease spillovers from animals to human populations, accounting for about 60% of infectious diseases of humans, have been increasing in frequency since the early 1990's (e.g., Bernstein *et al.,* 2022). Hence, the threat from infectious disease is increasing not diminishing. In such a situation we have to choose optimism and hope; action over inaction. It is an established principle that prevention is better than cure, and on that basis the cost of 'pandemic-proofing' our society through measures such as better surveillance of pathogens, reducing deforestation and improving our management of the wildlife trade, is estimated to be less than 5% of the cost of lives lost to infectious diseases each year, and less than 10% of the economic costs of another pandemic (Bernstein *et al.*, 2022).

Alongside these primary prevention measures there is a need for secondary measures to make our towns and cities more resilient to emerging infections and pandemic threats. Resilience can be achieved through appropriate investments in preparedness for future health crises, to build strong public health-care systems grounded in principles of human rights and equality for all. But how should we go about doing this? And importantly, how will we know when we've arrived at our destination?

2. Building resilience in local and regional health systems

As we have seen during the COVID-19 emergency, the first line of defence against a pandemic is an effective health system – one that though essentially static (that is, designed principally to meet every-day health and social care needs) can maintain its core functions and respond in dynamic fashion when subjected to health shocks. Responses, including testing, contact-tracing and treatment, need to be scalable: a major management challenge. We know that health shocks can be sudden, as when the spread of an infectious disease accelerates rapidly to become an epidemic, or slow-moving – for example, when antimicrobial resistance starts to place limits on choices for infection control. If a health system is not to collapse when faced with such shocks, it needs to have resilience built in from the outset. Thus, the key characteristics of a resilient public health system are that it should (after Kruk *et al.,* 2017):

1) be aware of its own strengths and weaknesses;
2) be conscious of external threats (fast or slow-moving);
3) be able to respond to a range of health and social care needs;
4) be able to draw upon necessary expertise from outside itself;
5) be integrated across different functions; and
6) be adaptive (agile), e.g., able to call upon surge capacity as the situation requires.

Experience tells us that these qualities do not arise spontaneously but require exhaustive design, planning and testing (in advance of, not during a crisis), and ongoing cultivation. This in turn requires a skilled and committed health-care workforce, sustained investment in public health infrastructure and strong health leadership at national, regional and local level. These things do not come cheaply but as noted above, taking preventative action now will be many hundreds of times less expensive – in both human and economic terms – than allowing another pandemic to rip through the UK population in the next few years.

At the heart of a resilient health system is its workforce and the diverse communities it serves. This workforce, whether in hospitals or community settings, needs to be thoroughly trained, well paid, well supported and equipped with appropriate personal protective equipment (recalling that the lack of stockpiled, usable PPE was a major gap in the UK's preparedness for COVID-19). Community groups including local civil society organisations and faith-based groups must be encouraged and given appropriate agency to contribute in a meaningful way to health-care system strengthening initiatives, for example by employing community champions to support local vaccination campaigns. This is something that will pay dividends not simply during a major health emergency such as a pandemic, but also help to reduce health inequalities in 'peacetime'. Equitable access to high quality care must lie at the heart of our preparedness for the next pandemic.

3. Next steps for UK cities

It is logical to argue that the goal of pandemic-proofing the UK's cities cannot be realised through a conventional single-discipline approach. Instead, it requires new thinking across multiple fields of research and its convergence with community voices; in other words, a holistic approach to disease detection, response and containment. This means

bringing together at sub-national level, groups of civic actors, health-care practitioners, academic experts and representatives from civil society to form pandemic prevention, preparedness and response (PPR) taskforces. The first job for each taskforce is to measure critical capacities within local health systems through triangulating epidemiological, clinical, laboratory, socio-economical, and behavioural data.

Thereafter, the taskforce's role is to collect evidence on good practice – what works locally – and make recommendations to national government to guide policymaking, planning and implementation of health-care interventions in advance of the next epidemic or pandemic. This would lead to a pandemic resilience plan for each UK Core City[1] or city-region (it is a moot point as to which of these geographies makes most sense from an implementation perspective, but the devolution agenda clearly favours the latter, e.g., recent 'Trailblazer' deals for Greater Manchester and the West Midlands that offer the prospect of local decision-making for health services). This pandemic resilience plan could be refreshed every few years after having been stress-tested to see if it works in a simulated public health emergency.

We propose that each PPR taskforce should report into a Local Resilience Forum. Thirty-eight such Forums were established in England and four in Wales under the Civil Contingencies Act 2004, with a remit that includes community risk assessments, emergency planning and certain aspects of emergency response and recovery (Cabinet Office, 2011). Note that slightly different arrangements apply in Scotland and Northern Ireland – see links in Cabinet Office (2011). Whilst Local Resilience Forums are not without their critics (e.g., McClelland and Shaw, 2023), strengthening their role by giving them oversight of pandemic resilience planning is a logical development in the wake of COVID-19 (see Case Study) and consistent with a 'whole of society' approach to resilience, as advocated in the UK Government Resilience Framework (2022).

What are the steps that need to be taken to create a PPR taskforce in each UK Core City or city-region? The starting point will be for the Department of Health and Social Care (UK Health Security Agency) to offer a small amount of funding under the auspices of its Centre for Pandemic Preparedness and nascent Health and Care Research Framework for Pandemic Preparedness and Response. This funding would be used to bring together in each city, community representatives, civic actors such as representatives from local authorities and mayoral combined authorities, health-care professionals working in hospitals and the community, and academics from diverse disciplines, such as data science and modelling, epidemiology, virology and other biomedical sciences, clinical trials, social, political and behavioural sciences, the arts and humanities, and environmental sciences.

To our knowledge such an approach has not been tried before in a UK healthcare context. It offers the potential to produce exciting breakthroughs in thinking and practice at a relatively modest cost, that could not have been achieved if pursued through the methodological framework of a single discipline. When convening such a PPR taskforce, the aim is to provide a 'safe space' for the exchange of knowledge from different spheres that in the past may not have worked. This safe space will support: 1) citizen empowerment in terms of local health-care decision-making, as envisaged in the UK Government Resilience Framework (2022); 2) integration of distinct disciplinary (academic and clinical) perspectives; and 3) creation of intersectoral teams to work together on the design of a resilient, equitable and inclusive health-care system for a given Core City or city-region.

We envisage that for the safe space to live up to its name, exceedingly good facilitation will be required to accommodate different experiences, expectations and capabilities, ultimately leading to agreement on new approaches to health-care system resilience. Training of such facilitators will be a prerequisite to getting the taskforces up-and-running. Achieving agreement between the different actors in each co-ordination taskforce will undoubtedly be challenging at times. But it is a necessary step in building a more robust public health system in the UK, thereby enhancing national pandemic preparedness, prevention and response ahead of a new emergency.

4. Case Study – Liverpool City Region

Assembling an interdisciplinary infectious disease research capability at city-regional level makes good sense if we are to implement key lessons from the COVID-19 pandemic. Liverpool City Region, a mayoral combined authority area characterised by large health inequalities, is an ideal place in which to prove the efficacy of this approach, having demonstrated its ability during the pandemic to think and act across

1 Core Cities UK is an alliance of 11 cities: Belfast, Birmingham, Bristol, Cardiff, Glasgow, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield.

Characteristics	Aims	Measures
Aware	Know health system capacity	1. Distribution of health system assets and weaknesses
		2. Health service utilisation trends
	Know risks and population	3. Presence of active epidemiologic surveillance system
		4. Functioning civil registration and vital statistics system
	Communicate	5. List of decision makers in key sectors
		6. Breadth of functioning communication channels
Diverse	Effectively respond to range of health needs	7. Scope of health services available in primary care
		8. Quality of care for sentinel conditions in basic package
	Adequately finance health systems; prevent financial harm	9. Financing of healthcare: adequacy of government health expenditure and financial protection
Self-regulating	Isolate threat and maintain core function	10. Memorandums of understanding with non-state providers
		11. Database of service delivery alternatives for affected and unaffected populations
	Leverage outside capacity	12. Collaboration agreements with regional and global actors
Integrated	Co-ordinate with non-health actors (education, transport, police, media, private enterprise)	13. Existence of a national emergency co-ordination system and leaders
		14. Frequency of joint planning sessions and drills
		15. Process for development of a One Health strategy
	Engage citizens and communities to build trust	16. Index of [Department of Health and Social Care] and government responsiveness to community need
		17. Population trust in health system
		18. Platforms for dialogue with community leaders
		19. In-country social scientists with experience working with health departments
	Link healthcare provision to public health	20. Availability of district health staff with public health training
	Co-ordinate primary and referral care	21. Agreement on roles and referral protocols for facilities
Adaptive	Shift resources to meet need	22. Formal provisions to reallocate funds in emergency
	Promote rapid local decision making	23. Management capacity of district or local health teams
		24. Agreements on delegation of authority and funding in crises
	Evaluate to improve	25. Mechanisms for, and capacity to, track progress and evaluate health system performance in crisis and in times of calm

Table 1: A resilience index for public health-care systems, after Kruk et al. (2017).

disciplinary boundaries, at scale and at speed. In the most challenging of circumstances, Liverpool City Council led the way nationally in designing an effective public health response to the novel coronavirus SARS-CoV-2, resulting in the world's first city-wide, voluntary COVID-19 rapid antigen testing pilot in November 2020. This was followed in December 2020 by early roll-out across Liverpool City Region of the national COVID-19 community testing scheme.

Co-ordination between health and civic partners in Liverpool's COVID testing programme was facilitated by CIPHA (Combined Intelligence for Population Health Action), an integrated data and shared analytics system established in only 12 weeks. At the same time, local authority directors of public health and their teams worked tirelessly to raise awareness about the benefits of asymptomatic testing and counter misinformation around test performance, resulting in extraordinarily high levels of public

engagement. Some 283,338 people, equivalent to 57% of residents, took at least one lateral flow test between November 2020 and April 2021. CIPHA data showed that positive tests for COVID-19 were spatially clustered in economically deprived areas, whilst revealing that take-up and repeat testing were lower in areas of high social deprivation, areas furthest away from test sites and areas containing populations less confident in using Internet technologies. This experience provides a powerful incentive to build a more equitable and inclusive health-care system in peacetime, to ensure that infectious disease testing and support to isolate is made more accessible to economically vulnerable communities likely to be most impacted by the next pandemic.

5. Measuring the resilience of health-care systems

Cities and city-regions are a particularly important scale at which to take forward the necessary pandemic-proofing preparations described here. The setting up of a PPR taskforce for each UK Core City or city-region would represent a major step forward in national resilience planning for epidemics and pandemics and allow benchmarking of city-regions against a resilience index such as that proposed by Kruk *et al.* (2017) (see Table 1).

This index is prospective, i.e., it can be used in advance of a crisis and has the advantage that its validity in a UK health-care context can be tested against actual performance during recent health shocks such as COVID-19. Once a baseline is established for each Core City or city-region, gaps can be identified and improvements in key metrics can be tracked over time. This approach to pandemic resilience could be adopted by the UK Government as part of its plan (see UK Government Resilience Framework (2022), paragraphs 98-100) to introduce new standards and frameworks that will strengthen national resilience in the face of civil contingency risks.

6. Summary and conclusions

We have argued here that inaction in the light of all that we have learned from COVID-19 is not a viable option if the UK is to avoid another staggering death toll from a future epidemic or pandemic. Yet, by all accounts we are far from ready for the next 'big one'. There remains much work to be done in the coming months and years, not least around improvements in infectious disease surveillance (DHSC, 2023; WHO, 2023). We do not know when or where an epidemic or pandemic will strike, so it is essential that we establish PPR taskforces as soon as possible. We will know that we have arrived at our destination of pandemic-proof cities when all of the preparedness gaps have been filled to the best of our ability, to the lasting benefit of citizens and communities.

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This policy briefing was originally published in November 2023.

Professor Clare Rigg, Jennifer Knights and Kennedy Myers

Public Service Leadership in a Digital Future - Lessons from the COVID-19 Pandemic

Key takeaways

1. Digital maturity: Public service organisations have demonstrated their technological readiness for exploiting digitalisation, with the pandemic also prompting some more exploratory innovations.
2. Space and Place of Work: The pandemic experience has dispelled many concerns regarding productivity from home working, and the resultant cultural shift towards remote working is predicted to endure. However, one size does not fit all – though suiting many, home based working is not feasible for others.
3. Virtual organising: Digital meetings have shown the potential to increase participation and engagement, as well as reducing time and cost spent on travel. However, full days of virtual meetings are more demanding than the equivalent in-person and replacing all encounters with formal meetings is leading to overload.
4. Digital Divide and Digital Exclusion: The pandemic saw a rapid transition to move many services to virtual provision. Some were surprisingly successful, which may lead to new and hybrid forms of future provision. Some organisations were able to bring more clients into digital access through close, supportive working. However, there is increasing recognition that a persistent proportion of the population, and particularly those vulnerable and reliant on public services, cannot access services online.
5. Implications for future leaders: Leaders in a digital future will need to be:
   - A virtual team leader
   - Emotionally intelligent
   - Digitally literate
   - Conscious of digital exclusion

1. Introduction

Faced with the COVID-19 pandemic, public service organisations responded rapidly to the March 23rd 2020 lockdown. Business continuity plans kicked in and almost overnight many services that could be delivered virtually went online, whilst workforces were catapulted into a world of remote working supported by digital technology.

Although the extent of virtual service delivery we have seen in the past year is unlikely to persist, no-one anticipates a return to the 2019 ways of working and providing public services. Pre-pandemic, digitisation and digitalisation were already widespread across public service organisations, with many also exploring the potential for more wide-reaching digital transformation. However, progress was slow and variable across different public service bodies.

This briefing reports **findings from a study** designed to capture lessons from this pandemic-induced transformation for future working in an increasingly digitalised world.

2. The critical policy challenge

Digital technologies are already widely used in UK public services organisations, but their rapidly widening application is predicted to have a transformative effect in the next decade. The policy challenge is to understand the implications for public leaders of digitalisation; how their roles are changing and what skills and capabilities they will need.

Our study comprised:

- A review of grey and academic literature on public service organisations, digitalisation and impacts of the COVID-19 pandemic on ways of working.
- Interviews with sixteen public sector senior and operational managers from local government, housing and health in Liverpool City Region as well

Key Terms	Definition
Digitisation	The process of converting information from a physical or analogue format into a digital one, for example, scanning documents, recording audio to a computer or making digital copies of old photographs. The business model does not change.
Digitalisation	Goes deeper, enabling, improving and/or transforming business operations and processes by leveraging digital technologies and use of digitised data.
Digital Transformation	A process that aims to improve an organisation by triggering significant changes to its business model through combinations of information, computing, communication, and connectivity technologies (*Vial, 2019*)
Digital Divide	The gap between individuals, households, businesses and geographic areas of different socio-economical levels with regard both to their opportunities to access information and communication technologies and to their use of internet for a wide variety of activities (*OECD, 2020: 5)*
Digital Exclusion	Can be defined as having no access to the internet. *(Elahi, 2020*)
Internet of Things (IoT)	The interconnection via the Internet of computing devices embedded in everyday objects, enabling them to send and receive data
Data Efficiency	Data efficiency is the process of making data easier to use, manage, and access *(Adams, 2020)*
Digital Maturity	The ability of an organization to respond and take advantage of technological developments that change how the market functions. *(Deloitte, 2020)*
Digital Capability	The ability of the organization to sense, seize and re-configure on the basis of digital opportunities in line with definitions of dynamic capabilities *(Teece, Peteraf, Leih, 2016)*

Table 1: Glossary of terms

as elsewhere in England and Scotland, including IT managers and digital leads. Participants were asked about their experience of transitioning when lockdown first occurred; the challenges, benefits and disadvantages of working and managing virtually; and what ways of working they would want to retain post-pandemic.

3. What did we find?

We found seven key themes with implications for managing a digital future: digital maturity; preferred ways of working; boundaries between work and home life; communications; leadership and management; data efficiency; digital divide; and access to services. Each are elaborated below, with illustrative interview quotes in italics.

Digital maturity

Digitally mature organisations show the capacity to respond to and take advantage of technological developments through both exploitation and exploration (Magnusson et al, 2020). They are digitally ambidextrous, in that they can simultaneously handle "established business activities and rapidly changing new digital activities" (Piccinini et al., 2015:12, cited Magnusson et al, 2020: 2). They not only exploit digital technology incrementally to achieve efficiencies through digitisation and digitalisation; they also explore the application of digital technologies to make innovative changes to the business model and/or modes of service delivery – what is described as digital transformation (Vial, 2019). Compared to private sector organisations, those in the public sector have previously been more likely to show digital exploitation because of constraints of funding, governance and decision-making processes. However, the disruptive effect of the pandemic has led to examples of digital exploration and innovation. Organisations were also driven to bypass conventional decision-making processes in an effort to distribute equipment and install data protection measures that enabled them to work remotely.

All those interviewed for this study described a rapid and relatively smooth response to the lockdown in March 2020. The pandemic cut through former cultural and political obstacles, propelling staff and organisations onto a steep learning curve, which has produced a number of surprising and positive conclusions. Organisations were typically technology ready – they had the software, which they previously were often not fully exploiting. The challenges experienced were more to do with hardware, licences and systems capacity to cope with an upsurge in online traffic.

> *"We were well placed to deal with the pandemic because we had a laptop estate. Very quickly after the lockdown, we were all at home on our laptops … all 4000 of us."* (Local Government Manager)

"We had been rolling out agile working across the workforce, a lot of people already had devices, so when lockdown came they could switch to home working quickly." (Housing Association Manager)

A rapid learning curve was common as staff learnt to use the software they already had at hand. A key component for this capability readiness was the availability of IT support staff and the willingness of individuals and organisations with knowledge to share their expertise.

Preferred ways of working

Prior to the pandemic, some were already advocating for agile working, including flexible hours and remote working, but facing opposition. Post pandemic, some have forecast a permanent change to ways of working, with a reduction in office space, permanent flexible working measures and a move away from the traditional 9-5 (or 8-6) core working hours. The enforced home-working during the 2020 pandemic has dissolved much of the resistance.

"It has accelerated our technical and cultural change massively … our chief executive was usually anti-working from home. It has advanced us years in terms of agile working." (Local Government Manager)

"HR fears that you can't work from home if you have a child at home. People have proven that they can." (Local Government Manager)

"People now know that working from home is not skiving. We already had a good understand of remote working in theory yet there were always managers that were reluctant." (Local Government Manager)

Almost unanimously, those interviewed expressed a preference for a future that involved no more than a day or two a week in an office. However, remote and virtual working does not suit everybody. Some, particularly younger and lower paid staff, do not have suitable spaces or working environments for working at home. Others need the structure and social contact of a work environment.

"Some people are desperate to get back to the office, because their domestic circumstances mean working from home is an unpleasant, difficult, complex experience. I think we need to recognise that we're going to have to come up with not one size fits all for this." (NHS Manager)

"We have a wide spectrum of staff who want to go back to work and some who have thrived at home." (Local Government Manager)

Boundaries between work and home life

Views varied as to whether the enforced home-based working improved the balance between work and life.

For some there was enhanced 'ability to control your circumstances' as well as the hours of work. Several commented that boundaries between work and home life seemed to have relaxed in a positive way. Others, however, experienced examples of intensification. It is unclear whether such intensification was the result purely of remote working or was exacerbated by the crisis of the pandemic. Nevertheless, it echoes other findings (McCarthy et al, 2020) that a major challenge people find with remote working is the difficulty of switching off. This highlights the necessity for managing work boundaries to avoid burnout and maintain well-being.

Communications

Communication with employees, citizens and customers has been pivotal during the pandemic and there was much evidence of thoughtful, deliberate and frequent communication through daily and weekly bulletins, staff surveys, a Chief Executive weekly video, as well as individual phone calls to clients. In addition, there were widespread attempts to replicate the informal 'water cooler' and 'corridor chat' settings of office interactions through the use of Zoom, Teams and other platforms.

Experiences with this world of exclusively virtual communication varied, with some interviewees identifying benefits, and others pointing to disadvantages. Benefits included a sense that digital platforms flattened the organisation hierarchy and made senior leaders feel more accessible to staff. Relatedly, several thought digital communication improved the level of participation and involvement of people, both within and outside the organisation.

"It's enabled us to work in a very non-hierarchical way … flattening hierarchy, feeling more connected to the, you know, the directors and the executive levels." (NHS Manager)

"There has been more cross team collaboration, more than there was before lockdown I think." (Local Government Manager)

Disadvantages of virtual communication included the loss of informal, opportunistic interaction: it was regarded as less effective for more complex interactions such as problem-solving innovation or resolving conflicts. The induction of newcomers to a virtual organisation was also presented as a challenge.

"The danger of remote working is that innovation happens when teams come together and when

you are brainstorming and having innovate ideas. You can't replicate that on Teams or Zoom. It's too formalised and innovation happens over lunch, at the water cooler, in the lift." (Local Government Manager)

Leadership and management

Prior to the pandemic, the literature already reported that a different management approach is required for remote working and virtual teams: one that is more outcomes-focused and relies on trust rather than visible presence. This was echoed by participants in this study. Many noted how the lockdown had exacerbated flaws within traditional management styles and elevated the more emotionally intelligent, flexible and innovative leaders, who could adapt to staff not being physically within sight, were able to delegate and could trust that their staff were still working.

"Managers have had to find different ways to engage with their teams. …Those managers that trust their staff have coped better than those who do not." (Local Government Manager)

Data efficiency

Data efficiency is the process of making data easier to use, manage, and access. The term goes beyond the position that data collection is a means to an end and acknowledges implications for investment in the right infrastructure to store, protect and access data. International responses to the COVID-19 pandemic provides extensive illustration of the potential for data sharing in digital health surveillance systems. The experience emphasises the importance of transparency and security to sustain the public trust that is essential if such systems are to be effective.

"I think that that has been a profound wake up and it hopefully will really accelerate public sector identification and realisation that cloud based solutions and particularly public cloud based solutions is the future." (Digital Health Lead)

Digital divide and access to services

A 'digital divide' captures a situation in which only some people have the relevant skills to use digital technologies and access their infrastructure, whilst others remain excluded. Prior to the pandemic, there was already research raising concerns that digitalised public services can both reinforce existing lines of social stratification as well as produce new forms of digital exclusion. Overall, the COVID-19 pandemic has deepened this divide and exacerbated the resulting inequalities (Elahi, 2020), although there are some contradictory examples, where organisations used the extreme situation produced by the pandemic to increase digital inclusion.

This study revealed examples where leaders only recognised existence of a digital divide and potential exclusion from digital services because of the sudden shift to remote delivery of most services during the pandemic.

"From an I.T. perspective, it has been something we don't really think about. We don't think about people's private life. We presume that everyone had Wi-Fi or mobile phones … it really has focused the mind that there is that gap." (Local Government Digital lead)

4. International context

Across the world and in multiple industries, the COVID-19 pandemic is seen as being a catalyst towards a more digital future. Similar lessons are being voiced, particularly with regard to the permanence (although not total disappearance) of reduced office-based working and increased remote working, as well as the continuation of virtual service delivery in many spheres.

Digital transformation of public services has been high on the agenda of governments worldwide for some years. Within the EU, Estonia is often hailed as an exemplar of digital public government although, alongside its strengths, areas are identified where other countries surpass (Kattel & Mergel, 2019). One such area is the lack of a central office to champion digital transformation, which, in the UK, is fulfilled by the Government Digital Service **https://www.gov.uk/government/organisations/government-digital-service**, with NHS Digital providing particular support for the health and social care sector.

International opinion now recognises that, although there is no single blueprint applicable to all contexts, best practice takes a digital governance approach rather than being led by technology. This means taking a holistic view of the institutional, organisational, fiscal and other frameworks that support digitalisation. The EU, for example, advocates a set of core principles to guide the integrated development of e-government, e-participation and e-services, including: Once only; User-centricity; Openness and Transparency; Security and Trustworthiness; and Accessibility and Inclusiveness (Leosk, 2019). In the UK, the Government Digital Service's standards mirror these **https://www.gov.uk/service-manual/service-standard.** However, as this study highlights, at the point of implementation, there are still lessons for how to achieve these, as

well as questions as to how far an integrated digital governance approach is being taken in service organisations.

5. Next steps

The COVID-19 pandemic has shown the readiness of many public service organisations for exploiting digital technologies for a future of increasing virtual working and service provision. It has also given us a sight of some of the risks, benefits and challenges of managing in an increasingly digitalised future, as summarised below.

Digital maturity

The digital maturity model is a potential way for evaluating effective vs ineffective digitalisation and determining what interventions are needed to produce both exploitation and exploration.

There are implications for public institutions to pro-actively shape digitalisation, and not just respond to the technological possibilities, with integrated e-governance. Legal protections for security, intellectual property and privacy need ongoing monitoring and updating to keep up with the pace of technological change. An access and inclusion lens would also help shape future innovation.

Space and place to work

- Use of time and space is likely to change permanently leading to an extended window of service provision and flexibility to work hours around family or other commitments;
- Boundaries will be important to protect employees from pressure to be digitally present throughout, to over work, or to be subject to excessive demands from others.

Virtual organising

- The future is likely to consist of hybrid meetings, with some members attending in person, and others remotely.
- A rethink of the purpose of synchronous meetings would be valuable, with consideration of asynchronous alternatives for some purposes.
- Management by outcomes not presence is likely to become more important.
- Contribution and participation in meetings will need to be valued, not physical presence, so as to avoid entrenching in-work inequalities. Staff will need to be encouraged to establish boundaries to avoid overload and burnout.

6. What are the lessons for managing in a digitalised world?

Leaders

Leaders in a more digitalised world will need to be:
- A virtual team leader
- Emotionally intelligent
- Digitally literate
- Alert to the risks of digital exclusion

Human Resource leads

In any enthusiasm to further exploit the potential of digitalisation to reduce office space and make cost savings, future policies for home-based working will need to recognise the diversity in staff, namely that some need to be office-based.

Digital leads

One clear implication for digital leads from this study is the reminder that a substantial minority of service users are either not digitally literate or not online, or both. This has repercussions when designing new services and systems, to consider how to improve access and connectivity.

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Dr Clarissa Giebel and Dr Kerry Hanna

Care home practices, mental health and staff support: learnings from the pandemic and lessons for future policy

Key takeaways

1. This research highlights the many shortcomings of the care home sector during the COVID-19 pandemic. These issues have been in place prior to the pandemic, and exacerbated further by the events of the last two years.
2. Our research indicates a need for an overhaul of social care career pathways and support structures: Staff need to receive adequate and freely accessible training and opportunities for career development to improve the value of the sector and staff retention. This also includes a need for easily accessible and free mental health support for all involved (residents, families and staff).
3. Social contacts are vital for residents and should not be removed again in the future, as evidence from the pandemic has highlighted the detrimental effects that removal of social connections can have.
4. Information and guidance from government, advising care homes of national protocol changes, must be clearly communicated, with social care staff involved in decision making
5. Care homes must aim for equitable care provision and visiting rights nationally, supported by national, evidence-based, government guidance.

1. Introduction

This policy brief assesses how the pandemic has affected the care home sector in the UK, specifically with a focus on families of care home residents living with dementia and care home staff. In October and November 2020, we conducted 42 remote interviews with family members and care home staff, 20 of which were followed up in March 2021. During the interviews, we asked participants about their experiences of care home visits and the effects of the pandemic on care home residents, as well as the impact of the pandemic on working in a care home. In the time between baseline and follow-up interviews, increased testing and vaccinations were implemented. Therefore, our follow-up interviews additionally focused on the potential effects of these public health changes on safe care home visitation.

This policy brief extends and builds on a previous **Heseltine Policy Brief** published in 2020, based on our COVID-19 dementia social care research. Previously, we discussed the implications that the pandemic and associated restrictions had on the lives of people living with dementia and their unpaid carers in Liverpool City Region (LCR) and beyond. This new paper takes a step further, looking at another angle of social care – the care home sector – and makes recommendations for the sector beyond the pandemic.

2. Care homes during the pandemic

Our research has highlighted four major issues faced in the care home sector during the pandemic (Giebel et al 2021). First, our research highlights how safe visits to care homes, including end of life care visits, were not enabled. This had a severe impact on families, residents and care home staff. Family members experienced growing levels of emotional upset and anger about their lack of access to relatives with dementia who were resident in care homes, without the barriers of windows, podscreens, or digital technology between them. Specifically, when increased testing and vaccination rollout began in early 2021, families were still not allowed to enter the care home, despite being fully vaccinated. However, COVID-19 infections remained an issue in some care homes, straining relationships between families and staff.

Second, there was a clear lack of government guidance on the balance between managing infection control and providing adequate care to residents. Care homes were left to determine their own policies, damaging care provision. According to our research, no care homes in England allowed face to face visitors during the winter 2021 lockdown, except for specific end of life care visits and mental health related visits, with individual care staff determining access on a case-by-case basis. Subsequently, we are aware that it took several months for care homes to independently decide to open their doors to face-to-face visits again.

Third, residents, families, and staff were left without mental health support in dealing with this highly emotional and chaotic situation. There was little psychological support in place, leaving staff and care homes residents to look after their own mental health. Even in light of the high mortality rate of residents no support was provided. Lack of mental health support for care home residents and staff was an issue before the pandemic, but the need for adequate mental health support has only been exacerbated during the pandemic. Mental health support needs to be provided by the NHS. While the NHS is ultimately responsible for mental health support, care home managers need to ensure all staff are able to access these services. In fact, family carers and people living with dementia should be registered to receive mental health support from the point of diagnosis, which is provided in memory clinics. In England, memory clinics are part of NHS Trusts and are used to assess people with dementia.

Finally, alongside this lack of psychological support, staff were faced with significant changes to their job roles with little support in adapting to new working practices. As such, staff were forced to adopt a greater emotional and familial role with the residents in the absence of visitors. However, the pandemic placed further constraints on the workforce. Staff had to comply with numerous infection prevention measures, altering their usual working practices to accommodate virtual visits and at times conflicting with their usual care giving. Participants reported staff choosing to leave their jobs due to these changes. A recent report from the Adult Social Care Workforce dataset confirmed an increase in the number of unfilled job vacancies within the social care sector (currently 4,300 unfilled jobs) since the pandemic (Skills for Care 2021). Moreover, the sector has previously been reliant on the non-UK workforce. However, post-Brexit immigration restrictions have significantly reduced the number of people entering the social care labour market. Only 1.8% of new starters between January and April 2021 were new arrivals to the UK, compared to 5.2% during the same time period in 2019 (Skills for Care 2021). These figures highlight the wider need for an urgent overhaul of the social care sector to make the sector safer, job roles more appealing, and thus attract and retain good quality staff. The introduction of mandatory COVID-19 vaccinations for social care staff from November 2021 has raised **concerns that some staff will leave the sector** because they are unwilling to be vaccinated. However, our research supports the need for vaccinating care home staff, as part of a broader overhaul of the sector.

3. The care home sector in Liverpool City Region

Before the pandemic, LCR faced high levels of social and health inequalities compared to other parts of the UK, including high rates of deprivation, ill health and levels of life expectancy lower than the national average (Due North 2014; NHS Liverpool CCG 2018). Within older adults and those living with dementia, inequalities have been found to exist through unequal access to support services, including delays in diagnosis and high costs of care (Giebel et al 2021a).

The pandemic exposed pre-existing health inequalities, such as poorly funded services within the social care sector, evidenced by the inability of care homes to cope with the virus spread and infection control in the early stages of the pandemic. Recent research by Giebel et al (2021b) identified pre-existing factors that prevent unpaid carers and people living with dementia accessing post-diagnostic dementia care, including transport, finance, and location. However, participants reported that poor access to dementia services persisted during the COVID-19 pandemic, and was even exacerbated for some, with reports of participants struggling to access basic necessities of food and medicine due to national lockdown restrictions (Giebel et al 2021b). This inability to access support during the pandemic resulted in higher levels of isolation, impacting the participants' mental wellbeing.

Liverpool has been hard hit by the pandemic, with COVID-19 responsible for at least 8,000 hospital admissions, and at least 4000 deaths in LCR so far (Public Health England 2021). There are over 300 care homes in the Mersey region, and 17,600 in the UK. Nearly half a million people are living in care homes across the UK, approximately 70% of which are living with dementia (ONS 2020). Thus, the impact of COVID-19 on care home residents is far reaching.

Research has highlighted that across the UK, there

were differences in how care homes responded to the pandemic restrictions due to unclear or unrealistic national guidance, with differences between care homes in their policies on visitors (Giebel et al 2021b). Nearly all unpaid carers we interviewed noted restrictions on meaningful visits with relatives in care homes, with only one carer reporting being able to see their relative in their own room. Between April and October 2020, 14,533 UK care home residents reportedly died of COVID-19 (ONS 2020). Care homes in LCR experienced higher rates of resident deaths compared to other UK regions (ONS 2021), and several care homes closed. In the Merseyside area alone, more than 700 care home resident deaths related to COVID-19 were reported by July 2020. Without immediate action in recovering from the effects of the pandemic, care home inequalities in the LCR will continue to widen.

4. What next for Liverpool City Region's care homes?

Our research in care homes during the pandemic has highlighted existing, exacerbated, and newly formed issues facing the care home and social care sectors. Care home and social care staff have been undervalued, underpaid, under-trained, and under-supported for too long, without a clear plan for improvements to the sector. Therefore, based on our research and taking into account the wider social care sector situation, we make the following four key recommendations for care homes in LCR, and beyond:

1. **Improved mental health support for all.** Residents, their families, and care home staff need to be provided with easily accessible mental health support. Care home staff often have little time to access such support, and may be hindered by poor and unsupportive working conditions. Care home managers need to be supported in enabling time and space for staff to access services. Mental health support for families and residents should be delivered by local NHS providers – as soon as someone receives a diagnosis of dementia, both the person with dementia and their key family carer should receive opportunities to access mental health support and support in living with the condition.
2. **Improved training and opportunities for staff to reflect on their practices.** Linked with mental health support, staff should be offered improved training in order to conduct their job. This is particularly pertinent given the changes in working practices since the pandemic without adequate guidance. Training should focus on how to provide care for vulnerable older people, including those living with dementia; engaging with family members; and managing behavioural and cognitive symptoms in dementia.
3. **Improving the image of the adult social care job sector.** The sector needs to be provided with clearer career pathways, which enable well-skilled and dedicated staff to develop and stay within the adult social care sector, and retain their learning. This also includes better pay which reflects the job demands and skillsets required.
4. **Protocols for safe visiting in care homes during pandemic circumstances.** We now have evidence showcasing the detrimental impact that social isolation in care homes, compounded by the lack of understanding due to cognitive deterioration, can have on the lives of people living with dementia in care homes. We also have evidence showing the negative impact on families. Thus, for future possible COVID-19 waves and other pandemics, protocols for safe visiting need to be put in place and readily available. This is precisely where guidance during COVID-19 in the UK fell short, whilst other nations such as the Netherlands provided strong guidance in May 2020.

5. Conclusion

If we fail to act, the social care sector - already in crisis - will not be fit for purpose, preventing some of the most vulnerable members of our society from receiving the care they need and deserve. If these suggested policy changes are neglected and not addressed, the sector risks losing even more staff. To improve staff retention, clearer career pathways are required, along with better pay, improved support on the job, access to mental health support, and opportunities for shaping policy and decision-making processes in the sector. These changes can help improve the value of the social care sector, and help retain and recruit more staff.

The introduction of the Health and Social Care Levy in April 2022 represented an opportunity to address some of the shortcomings of the social care sector. However, of the £30bn in additional funding over the next three years, **only around £5bn will go to social care**. Much of the remaining funding will be channelled into the NHS. Local authorities meanwhile are stretched financially, limiting their ability to allocate more resources to social care. While extra funding for health and social care is welcome, it is essential that this funding is directed in the right way to improve services, particularly in areas where there is most need.

The policy implications and recommendations outlined here are not unique to care homes, but equally applicable to the social care sector more broadly. Paid home care staff, which provide vital care for older adults, people with dementia, and enable other vulnerable members of the population to stay at home well and independently, are also an important part of the social care sector. The overall aim of social care is to support people to live well in the community, in their own home, for as long as possible and avoid care home entry altogether. Therefore, to address the crisis in care homes, it is important that provision of social care as a whole must be reformed to ensure older and vulnerable people, and their families, are supported.

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Dr Koen Bartels

Social prescribing: what's strong and what's wrong – lessons from the Wirral

Key takeaways

1. Social prescribing of people to community-based activities that strengthen their wellbeing creates an opportunity to address both health inequalities and collaborative relationships.
2. This opportunity will be missed without an asset-based ecosystem of social prescribing that:
   a. reinforces 'what's strong': local assets that enable communities to feel well.
   b. transforms 'what's wrong': unequal relationships between local authorities, NHS and voluntary, community, faith, and social enterprise organisations.
3. Key elements of an asset-based ecosystem include:
   a. continuous building of relationships of mutual understanding, trust, and support;
   b. safe spaces for incubating and sustaining grassroots innovations;
   c. inclusive and equal decision-making forums;
   d. joint inquiry and learning driven by community assets and needs.
4. These lessons are based on the case of the Wirral, which has a burgeoning social prescribing provision grounded in a well-established asset-based approach, but faces structural issues with collaborative relationships.
5. Creating asset-based ecosystems for social prescribing across the UK is a way to realise policy aims for a social model of wellbeing that enables more equal and sustainable health and social care.

1. Social prescribing and asset-based working

Social prescribing is a way to address the wider determinants of health by referring people to social, cultural, environmental, or economic community-based activities that help to address medical and non-medical issues. While there are a wide range of approaches, key elements are a prescription by GPs or other health care professionals to a 'link worker' or other public service professional, who co-designs a personalised care pathway based on a 'what matters' conversation and knowledge of local assets (NHS England, 2019).

Social prescribing is widely promoted as a pathway to move away from a *medical model* – focused on individual health determinants, individual responsibility, medicine, and service-driven care – that is both clinically and financially unsustainable on the long term.

In light of growing concern over the affordability of an over-pressured NHS and our reliance on medicine more generally, the ambition is to move towards a *social model of wellbeing* – focused on the wider determinants of health, place-based working, preventative practice, patient-centred care, increased service integration, and service delivery by Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations, in partnership with the public sector.

In the context of policies such as *The NHS Long Term Plan 2019* and the *Health and Social Care Acts* 2012 and 2022, social prescribing offers a unique opportunity to reduce post-pandemic health inequalities within and across communities, while transforming relationships between public health bodies and VCFSE organisations towards genuine co-production of community wellbeing.

The purpose of this policy briefing is to clarify how creating an asset-based ecosystem can enable all those involved to realise this transformative opportunity. Asset-based working has recently gained popularity across the UK (LGA, 2020). Deriving from Asset-Based Community

Development (ABCD), its defining characteristic is to focus on 'what's strong' (assets[1]) rather than 'what's wrong' (deficits) to create well-connected communities and mobilise them to address structural inequalities (Kretzmann & McKnight, 1993).

There is evidence that an asset-based approach to social prescribing has unparalleled potential to enhance access to what communities need for wellbeing and address structural issues that limit the extent to which it is effective and co-produced (Dayson, 2017). Illustrated by a case study of the Wirral, this policy briefing shows the value of developing an asset-based ecosystem in focusing on 'what's strong' and the ongoing challenge to transform 'what's wrong'.

2. An asset-based ecosystem for social prescribing

Social prescribing faces a myriad of structural issues. Historically, place-based partnerships and community engagement in health and wellbeing struggle to translate ambitious targets into meaningful relationships and measurable impacts (Cropper et al., 2007). Despite ambitious plans for cross-sector collaboration, a recent study by the Nuffield Trust identified that Integrated Care Reforms "have so far been insufficient in substantially addressing the culture, norms, systems and processes needed to support integrated ways of working and fundamentally change the way services operate" (Buckingham et al., 2023, p. 1). There have been **calls for a rethink of how the VCFSE sector operates** in the context of integrated care (Swift and Burbidge, 2022). The perpetuation of these structural issues in the context of social prescribing is perhaps unsurprising. The *Care Act 2014* limits co-production to citizen voice to influence delivery, design, and commissioning, rather than ongoing collaboration that facilitates a range of different roles for communities to distribute power more equally and inclusively (Loeffler, 2021).

Creating an asset-based ecosystem can help overcome current limitations in addressing these structural issues. The main driver of this ecosystem would be the principle that all decisions, support structures, and relationships are *community-driven* rather than institution-led; i.e. "based on the principle that communities have a wealth of knowledge, skills and assets which mean they are well placed to identify and respond to any challenges that they face, and to thrive" (Pollard et al., 2021: 116). While there is a risk of adding to communities' burden of responsibility in a time of unprecedented wellbeing challenges, there is also a risk of adding to feelings of marginalisation when not listening to and collaborating with communities.

The key elements of an asset-based ecosystem are:

1. Continuous building of relationships of mutual understanding, trust, and support between stakeholders. Structural issues can only be addressed if stakeholders have relationships that allow them to challenge each other to learn and change.
2. Safe spaces to incubate and sustain grassroots innovations through resource sharing, mutual support, and experimentation. Supportive funding and frameworks will allow innovations to develop away from the demands of competitive and hierarchical pressures.
3. Decision-making forums that include diverse VCFSE organisations as 'legitimate stakeholders', facilitators of community-driven action and change and representatives of local communities. Inclusive and equal co-production increases joint capacities for developing innovative ways to address structural inequalities.
4. Joint inquiry and learning about how to develop a 'shared practice' driven by community assets and needs. Critically examining diverse views and experiences builds abilities to adapt and change in the face of emerging challenges.

Creating such an ecosystem across multiple forums and spaces could support social prescribing to become an economically sustainable and collectively supported alternative to an overly individualised approach to health and wellbeing, which is inadequate for addressing alarming levels of inequality and sustaining genuine community-driven co-production of wellbeing.

3. Social prescribing in the Wirral

These lessons are based on the case of social prescribing in the Wirral, a borough in Liverpool City Region including some of the most deprived and most prosperous wards in the UK, with a shocking difference in life expectancy between these wards of up to 20 years. Similar to other places in the UK, it faces serious local authority budget constraints, pressures on NHS services, and a need to better join up services. In this context, social prescribing to

1 An asset is understood to include anything that can support the wellbeing of individuals and communities, such as talented individuals, personal relationships, social networks, community groups and organisations, buildings and green spaces.

community-based initiatives can help to address issues such as a long waiting lists for child and adolescent mental health services (currently standing at around 40 weeks), but also risks being a mere sticking plaster on poor service provision and unequal outcomes.

As reflected by the Healthy Wirral plan (2018), social prescribing is at the heart of place-based collaboration on the Wirral. There are multiple providers socially prescribing people to a burgeoning network of community-based initiatives that support the wellbeing of local people and places. These include **Make It Happen Birkenhead** (which hosts a community hub and retail shop), **Rites for Girls** (which supports adolescent girls), and **Grow Wellbeing** (which organises nature-based activities such as outdoor play and community gardening). The various schemes that socially prescribe people illustrate the diverse approaches available:

- **Connect Us** (Involve Northwest): Community Connectors facilitate 'positive wellbeing interventions' that support people in developing their potential to achieve their aspirations.
- **Wirral Social Prescribing Scheme** (Citizens Advice Bureau): Link Workers support people to improve their wellbeing, including social isolation, employment, housing or long term health conditions.
- **Care Navigators** (Child and Adolescent Mental Health Service): a single point of contact for children, young people, and their families to address mental health and wellbeing issues.

What ties this diverse social prescribing provision together is their origins in an asset-based foundation. In 2014, Wirral Council, Wirral Clinical Commissioning Group (CCG), and Cheshire and Wirral Partnership NHS Foundation Trust (CWP) supported the development of an ABCD Network. Leading ABCD consultancy **Nurture Development** was commissioned to help rebuild collaborative relationships and enable asset-based change in disempowered communities. While this contract ended after a few years, health and wellbeing provision across the Wirral continues to be shaped by a commitment to focus on what's strong, co-producing person-centred care, and connecting with others, community and environment around local assets that enable people to feel well.

Monthly *Community of Practice* meetings cultivate mutual understanding, trust, and support around community assets. Participation is voluntary but averages 30-50 representatives from VCFSE, health, and public service organisations, with membership continuing to develop and grow. Meetings have an informal structure, with a facilitator but no minutes, and focus on showcasing each organisation's work and how it links to others. The continued appeal and impact of the *Community of Practice* is threefold:

- Promoting reciprocal rather than transactional relationships by moving the focus from each partner's individual agenda to a joint focus on local assets and needs. For instance, it helps specialist services to understand what activities individuals can access in the community, and recognise that all sectors have something to offer.
- Helping organisations which are part of the large and diverse VCFSE sector to feel connected.
- Addressing the tendency for procurement processes to create competition between organisations by building trust in the value and capacities of the VCFSE sector.

The *Community of Practice* is a vital forum in light of structural issues in the relationships between the VCFSE sector, Wirral Council and NHS, including commissioning, transparency, and power. There is a continued tendency for Primary Care Networks to take an instrumental approach to community-based organisations. It is all too common for preventive healthcare to shift its focus from community advocacy to outcomes-measures suiting funder's priorities. This is partly inherent to the term social prescribing, which reinforces assumptions of medical power and not community control. Another challenge is that the amount of work and time involved in making funding applications favours large organisations over small organisations. The *Community of Practice* helps to highlight processes that create distrust and cultivate an environment of reciprocal relationships.

However, the potential of the *Community of Practice* to overcome small-p politics and engrained power inequalities is limited. The focus is on talking and sharing and not joint learning, advocacy, or action. Decisions are made elsewhere and there is a plethora of other forums, all with different remits and geographical coverage, where the VCFSE sector has little representation or influence. Infrastructure organisations could play a key role in addressing this, but currently do not have a position or resources that would enable them to do so.

The strategic value and benefits of social prescribing are widely recognised across these forums. But holistic approaches to wellbeing and community-driven change tend to dissipate in the face of silo-working, pre-determined policy priorities, performance and evidence expectations, and complex partnership

schemes. The Health and Wellbeing Board, Wirral Place Partnership Board, Senior Leader Network of VCFSE organisations, Community, Voluntary and Faith Sector Forum, Wirral Sustainability Board, and CWP Primary Care Network Forum have all recognised the need to become more inclusive and holistic. While welcome steps are being taken for greater inclusion of a wider diversity of VCFSE organisations, there continues to be a lack of strategic engagement with these organisations and doubts about whether these forums are recognised as legitimate.

This leaves many of the VCFSE organisations on which social prescribing depends under constant pressure to secure project funding while lacking sufficient time or capacity for networking and crafting funding applications. The research conducted for this briefing suggests VCFSE organisations feel overwhelmed with 'scattergun' emails and information coming from the plethora of forums and frustrated with the lack of structural support materialising from these. This precarious situation risks turning social prescribing into a sticking plaster for austerity reforms rather than a vehicle for place-based collaboration.

There have been some developments in the direction of creating an asset-based ecosystem. In 2021, the Wirral Health and Wellbeing Board (HWB) commissioned community broker Community Voice to help establish and facilitate a VCFSE Sector Reference Group. The Reference Group was to advise and inform the HWB from the position and knowledge of the VCFSE sector on the design of integrative systems with the main aim of reducing health and wellbeing inequalities. It has grown to include well known, connected, and respected representatives from across the sector and supported several community-driven initiatives and proposals. However, it has been developed on a voluntary basis, has no resource, and is not yet formally constituted. Its proposals have so far been positively received but not supported with either commitment or resource.

An important step towards creating an asset-based ecosystem on the Wirral would be positioning the Reference Group as a central intermediary. Another would be co-producing a Green Space Infrastructure (one of the proposals supported by the Reference Group) that would support small community-based organisations to develop green social prescribing activities and secure land ownership.

4. Conclusion

The case of the Wirral showcases that an asset-based foundation for social prescribing can cultivate relationships of mutual understanding, trust, and support for sustaining 'what's strong': a rich texture of local assets for community wellbeing. Its *Community of Practice* nurtures a continued focus on community assets across VCFSE, health, and public service organisations. Yet, it also reveals that the sustainability of social prescribing can be threatened by the lingering of 'what's wrong': structural issues with collaborative relationships. Structural inequalities in participation, influence, and funding support make it difficult to sustain the very initiatives on which social prescribing depends.

Creating an asset-based ecosystem extends a strong relational foundation with safe spaces for grassroots innovation, inclusive and equal decision-making forums, and learning how to work and change together in a community-driven way. For social prescribing to transform health inequalities, public health bodies need to recognise the importance of empowering VCSFE organisations and integrating them into policy-making, rather than seeing them as dispersed service providers who are, at best, consulted on the design of new health and social care systems. This is not easy to do. It asks for a community of practice that facilitates public health bodies and VCFSE organisations in learning and changing together around how to develop and sustain such a social model of wellbeing.

More sustainable and equitable health and social care are of strategic importance to regional and national government agendas. It is at these levels that priorities and budgets for health and social care and levelling up are set and ambitions for a social model of wellbeing have been articulated. Regional and national policy-makers need to be engaged in co-producing the conditions and resources needed to enable social prescribing to realise the wellbeing model and outcomes they aspire. There could not be a better and more pressing time to work out together how we can create asset-based ecosystems for social prescribing across the country.

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Enabling Community-led Housing in England

Key takeaways

1. Community-led housing, which incorporates a range of approaches including community land trusts, cooperatives and cohousing, could contribute to meeting the new government's housebuilding targets by improving community satisfaction with housebuilding, contributing to diversity in the market, and raising design and build standards.
2. To scale up the community-led housing sector, communities need access to knowledge and intermediary support. However, as recently piloted funding streams have ended, community-led housing enabler hubs have struggled to be sustainable.
3. The short-term funding cycles common in community-led housing have overburdened organisations and made it difficult to attract and retain skilled housing practitioners. Going forward, this work requires secure, long-term funding mechanisms and revenue models.
4. Intermediary actors could be the drivers of a more secure and professionalised sector. For example, targeted investment in intermediaries to support proven, locally achievable models could deliver greater scale and replicability. Beyond specialised intermediaries, some support capacity could be provided by professionals in other organisations such as local authorities, housing associations and private consultancy.
5. However, the independent character of community-led housing schemes needs to be retained. Funding bottom-up community activity can lead to further experimentation and deeper community engagement.

1. Introduction

Housebuilding is a key government priority, with the need for many new homes well-established. **The new Government has committed to building 1.5 million homes in the next five years.** The volume of new homes built is a key aspect of this, but it is also important that the right new homes are built in the right places. In 2019, a survey suggested that just 2% of the public trusted large-scale housing developers to deliver the homes they need and only 7% trusted their local council to make decisions about large-scale development that were in the best interests of the area (Grosvener, 2019). Problems with the prevailing volume housebuilder approach include poor quality and place-making of large new developments (Goodchild, 2021), under-delivery of affordable housing and infrastructure (Colenutt, 2020), and a lack of diversity in the market which does not support small and medium-sized enterprise (SME) builders or delivery on smaller sites (Foye & Shepard, 2023). There is often significant opposition to new development, based on the impact on the local area, creating a challenging situation for local authorities that need to meet housing targets but do not want to impose unpopular or inappropriate development on existing communities (Inch, 2020).

Community-led housing could offer part of the solution to these housebuilding problems, but the sector faces significant challenges to its growth. 'Community-led housing' encompasses various approaches like community land trusts (CLT), cooperatives, cohousing, and self-build housing, emphasising civic control over housebuilding and management (Field, 2020). These practices have been recommended as a mechanism that can work to fill in the gaps between what can be achieved by the market and what can be achieved via housing associations and local government (Field and Layard, 2017). Beyond this contribution to the housing market, community-led housing research suggests community-led housing can contribute to the health and well-being of residents (see McClatchey et al, 2023).

Despite rising interest from the public, civil society and some politicians, the overall output of the sector has remained low. The current number of homes previously built by the community-led housing sector is estimated at

around 26,800. This represents around 1% of England's housing stock (Smith, 2016). The vast majority of these homes are legacy housing cooperatives, established in the 1970s and 1980s during a period of government investment. CLTs are currently the most prominent model of new development and the national CLT network puts their contribution at around 1,711 affordable homes completed so far with 5,413 homes in the process of development. Public interest in the sector has been growing, for example, the number of registered cooperative housing organisations has risen nearly 50% from 685 in 2018 to 900 in 2023 (Holmes & Candlin, 2024). The Community Led Homes coalition estimates there are currently 21,700 community-led homes in the potential pipeline. The CLT Network estimates that there is a market opportunity to develop as many as 278,000 community-led homes with the appropriate support (CLT Network, 2023).

This briefing details some of the barriers to growth for the sector, in particular access to enabling support for community-led housing activity. The findings and recommendations are drawn from research that explored community-led housing development in England, including through three regional case studies, a recent overview of the national sector and a workshop with community-led housing sector stakeholders.

2. The benefits of community-led housing for housebuilding

The research showed that one of the most important benefits of the community-led housing sector is the 'additionality' of the homes that are built. One interview participant, a housing team leader working in a local authority, explained:

"The advantage of these was these homes that really wouldn't have been built any other way. You know, they wouldn't have been built as exception sites, affordable sites or open markets. So, they are genuinely additional to anything else we've got coming forward."

At a local level, affordable housing development on smaller sites may enable individuals to stay in areas where they grew up or make efficient use of small parcels of land. For example, community-led housing has been promoted as a key solution in small villages with high second-home ownership, which have generally lacked affordable housing (Moore, 2018).

The findings suggest the community-led housing sector is finding ways to overcome local concerns over housing delivery. A participant from an intermediary organisation supporting CLT development in rural areas described their experience:

"Everywhere I go, there's a community that says, we'd like to do this ourselves because the last time we had affordable homes built, they put it in the wrong place. And they look wrong and they're housing the wrong people and they're not managing their properties properly."

This community control may be able to turn negative community attitudes toward housebuilding into positive engagement in local development. An interview participant working within a combined authority noted:

"[The communities] don't love development, you know, if they could just not have it, that would be great. But [their attitude is] it's better the devil we know, like, it's better to do it ourselves, and at least have some control and do it the way that we would want it."

This positive mobilisation of the community has led to the delivery of large sites with a mix of affordable and market housing, with significant oversight by the community. This model of engagement with a CLT may be appropriate for unlocking larger sites for development facing significant community opposition.

Due to their bespoke and small-scale nature, the community-led housing sector may contribute to promoting housing market diversification, supporting SME developers to deliver more homes and raising the bar for quality in the new build industry. The sector's qualities of small-scale development with an emphasis on design, sustainability and community also suggest innovation and a role for SME builders and developers. A stakeholder from the Ministry of Housing, Communities and Local Government (MHCLG) explained:

"That's another reason why we like the community-led housing sector is that it helps to sustain the SME builder sector, which adds to the sort of robustness and resilience of the house-building industry generally and intends to deliver variety and helps to meet additional markets, which aren't going to be developed by the sort of the mainstream house builder model."

Ultimately, the contribution of the sector could therefore be beyond the additional homes built, but also in contributing new ways of working for sustainability and community engagement that improve delivery across the industry. However, for these benefits to be realised the sector's scale and impact must increase.

3. What support does the community-led housing sector need?

Most citizen groups lack the knowledge and connections for housing development, making access to support crucial for equitable community-led housing benefits. A network of enabling professionals and intermediaries has developed to support volunteers to engage in a housing development (Moore and Mullins, 2013; Fernandez Arrigoitia & Tummers, 2019). This has included support services based within local authorities, third-sector organisations acting as intermediaries, networks of volunteers promoting peer support, and freelance professionals. This has been paid for in a variety of ways, but generally through revenue grant funding to individual groups or local authority contracts to provide support. Generally, the availability of this support has varied widely by region.

In recent years, there have been efforts to extend this enabling support across England. National sector actors lobbied and received funding for regionally based community-led housing enabler hubs as part of the second phase of the Community Housing Fund. These formed a network of 28 enabler hubs across England, a mix of pre-existing intermediary activity and newly formed hubs. Start-up investment was provided in 2018-2021, from both central government and major charitable funders (Lang and Mullins, 2019). An evaluation of the Power to Change enabler hubs showed that in operation they contribute to an increased pipeline of community-led housing developments (Arbell et al, 2023).

Despite early signs of success, the findings from this research indicate that since the conclusion of the funding streams, many enabler hubs have scaled back activity significantly or closed. A research participant whose own third-sector organisation had recently stopped operating an enabler hub summarised: *"In a lot of parts of the country, it's just gone".*

Designers had intended enabler hubs to become financially independent through a fee-based model on housing completion. This approach was based on the model of a CLT intermediary in the South West that had demonstrated financial sustainability with limited revenue grants for CLTs in partnership with housing associations. However, for many hubs, this model was not workable, especially within the timeframe. Some enabler support has continued, this includes the original CLT intermediary that inspired the model of the funding. Other intermediary organisations still operate, and some have developed asset-based models or maintained contracts with local authorities or city regions that created some level of sustainability. Where this is occurring, local authorities should seek to protect these organisations against funding shortages and ensure continued operation.

As the most recent models of intermediary support have generally not been able to achieve independent financial sustainability, other forms of provision of intermediary support may also need to be considered. This might include intermediary organisations that are targeted at specific replicable models of community-led housing, diffusion of community-led housing knowledge among other relevant professionals and support for national-level intermediaries able to coordinate freelance professional support for groups. The key ask of the sector in this regard is access to funding streams

that can provide technical advice, including grant funding which can be utilised to pay for risky earlier stage work. The organisations and models through which this technical advice is delivered may vary across different areas. The **community-led housing training programme** led by the Confederation of Cooperative Housing has so far been an effective distribution tool for knowledge to other professionals. These organisations should continue to invest in the training of their employees, or charitable funders should consider investment in training for small third-sector organisations that can engage in bottom-up community development, retaining the experimental and grassroots nature of the sector.

4. Scaling up the community-led housing sector

Previous research has covered the extensive challenges of small volunteer groups in accessing land and funding for community-led housing development (Heywood, 2016; Goulding, 2018). Ultimately, within a market-based system, these challenges are likely to remain. Therefore, government support through land disposal, grants and financing is likely to be an ongoing requirement. Government investment, through local authorities or Homes England, already seeks to incentivise strategic housing development through derisking development sites and providing supporting infrastructure. Support for community-led housing groups to access the market should be considered in line with this model of housing market investment.

Direct government funding through the Community Housing Fund phases one and two provided an

important boost for the sector. This included dedicated access to capital funding, rather than through the mainstream affordable

housing fund. Practitioners in community-led housing involved in this research favoured this approach as it better considers the risk that community groups face on each site versus the risks of larger providers which are spread across their multiple sites. A participant with experience of community development and the funding process within Homes England explained:

"And of course, their ability to borrow money is completely different for a community organisation is much more expensive, because it's much more risky…And quite often they need more grants because they're doing higher design quality, higher sustainability quality. So, in value for money assessments, they don't score as well as the big providers… So, you know, that's where the Community Housing Fund was a better route in my view because it recognised that these were different providers and that what they required was different, which is why the sector continues to lobby the government for more funding for more years."

However, a larger-scale sector could also begin to support itself more effectively. Part of this solution may also be an investment in intermediaries that support proven models of delivery such as rural CLT development (Moore, 2018) or infill in low-density suburbs with community support (Lloyd, 2023). This approach has been championed by national intermediary bodies through their **Growth Lab initiative**. Additionally, the sector has proposed a Community-led Housing Growth Fund, supported by an initial government investment, to attract private and social investment and empower intermediaries to support the growth of the sector at scale. The **Community Led Housing network** a coalition of sectors made up of the **Community Land Trust Network,** the **UK Cohousing network** and the **Confederation of Cooperative Housing**, has suggested £150 million Government investment could provide the leverage to access the commercial finance the sector needs to grow. These approaches are based on the idea that finding ways to blend bottom-up and top-down approaches, through greater sector-level leadership and a more professionalised approach could unlock the potential of the community-led housing sector to support significantly more homes.

The problems of support for the Enabler Hub programme are indicative of wider-scale disruption and insecurity in the community-led housing sector. A participant stated:

"[There will be] a completely different pot of money with different criteria and so on. Most inefficient way of working that anybody could ever come up with really… And that's one of the structural problems is all of this stop-start stuff, which is a complete waste of everybody's time."

Furthermore, start-stop funding creates instability in the professional careers of enabling workers. This has contributed to problems with attracting and retaining staff to the sector. An enabler hub director stated in an interview that this has caused problems with organising work:

"When that funding drops off, people have to go off and get other jobs. So then work comes in and you realise we don't quite get enough people to do as much as we'd like."

Therefore, a model for long-term and reliable enabler activity is required, but one that drives the scale required to contribute to the sustainability of the sector.

Whilst the funding ask from the government for these approaches is significant, it is only a small percentage of other forms of housing market subsidy directed to other delivery models and tenures, such as the Help to Buy Programme or infrastructure grants (Wilson, 2021) or direct payment for housing through the benefits system (Diner, 2023). This investment would lead to capital that would remain within the community to be leveraged to support maintenance and further housebuilding. This should be considered a serious route to achieving quality, affordable homes that offer residents security, dignity and control. Investment and support could create a virtuous circle that leads to increased scale of the sector, increasing diversity in the overall housing market. However, for these benefits to be realised this support needs to be predictable for the longer-term, for a significant number of projects to complete and begin to create self-sustainability. In an environment where the UK needs to build a lot more houses, it seems community-led housing is not just an attractive model but also necessary to add more diversity to a developer-dominated sector.

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Dr Wayne Shand

Social housing retrofit: building a dynamic delivery programme

Key takeaways

1. The scale and cost of social housing retrofit needed to achieve net zero targets requires a new approach to funding, financing and delivering housing improvements.
2. Major capital investment in social housing retrofit provides an opportunity to capture skills, employment and economic benefits for local communities. These benefits should be built into retrofit programmes, with targets set for contractors during procurement processes.
3. Effective use of data can drive dynamic programming of delivery and build a framework to enable priority setting and financial planning.
4. The need for social housing retrofit provides an important incentive to accelerate skills training to reflect changing regulations and technology in green construction.
5. Wider partnerships of social housing providers, contractors, colleges and government are needed to reach net zero goals at scale.

1. Introduction

UK government has set a binding target to reach net zero greenhouse gas emissions by 2050. Decarbonising housing forms a key element of delivering this national goal. In the UK, residential buildings contribute around 15 per cent of overall greenhouse gas emissions (HCLG Committee 2021) with some 29 million existing homes needing to be made low-carbon, low-energy and resilient to climate change (Committee on Climate Change 2021). Social housing, provided for rent by housing associations and local councils, constitutes a significant part of the housing stock. In England, there are some 4 million properties in the social housing sector, representing around 17 per cent of homes (BEIS 2021). While social housing has, on average, better energy performance than homes in the private rented sector, with for example 62 per cent of social housing having wall insulation compared to 32 per cent of private rented housing (HM Treasury 2021), delivering decarbonisation is a major challenge for local councils and housing associations.

This policy briefing explores the practical aspects of designing a social housing retrofit programme through a case study of the London Borough of Camden. The briefing draws on work undertaken by Inner Circle Consultants with Camden Council in 2021. It focused on two primary outcomes: firstly, the design of a dynamic programme to phase retrofit works to the Council's stock of 33,000 properties; and secondly, enabling the Council to maximise the local employment, skills and economic impact from the major programme of retrofit capital expenditure.

2. Social Housing and Net Zero – Meeting the Challenge

Decarbonisation of social housing presents a range of financial, technical and operational challenges for councils and housing associations. These challenges are exacerbated by both the scale of the task and by the diversity of social housing portfolios, which within local areas can range from individual historic street properties through to large housing estates. The unique configuration of place requires the design of specific long-

term (10–30 years) programmes that are locally tailored, financially affordable, technically coherent and deliverable by a construction sector which is experiencing rising growth in demand.

As set out by Clare Rainsford of Onward Homes in **a Heseltine Institute policy briefing (PB206)**, there are three core elements to decarbonising existing dwellings: reduce energy consumption; reduce energy demand; and install low carbon heating. The most effective way to achieve energy efficiency gains is through whole-house retrofit, where improvements are made simultaneously to the fabric of the building and to the heating method. However, this holistic approach is expensive and can be disruptive to tenants, meaning that a more incremental approach, which prioritises fabric improvements plus heat decarbonisation is likely, depending on the configuration of the housing stock.

Key elements of delivering net zero housing are:

- improvements to the energy efficiency of dwellings through installation of internal or external wall insulation, reducing heat loss through floors and roofs and upgrading of windows and doors;
- replacement of gas boilers with ground or air source heat pumps, or electric boilers that draw energy from renewable sources; and
- where appropriate, installation of energy micro-generation systems, such as solar panels.

Making these improvements across the social housing stock presents a number of challenges.

Firstly, funding of social housing retrofit is a major issue for councils and housing associations. While private finance is available in the market, existing models of repayment based upon future income streams from energy savings are untested, creating perceived risks for both lenders and landlords. Research undertaken for the National Housing Federation (Savills 2021) indicates that, in addition to existing planned expenditure, £36 billion is needed to bring all housing association homes up to a minimum EPC C energy rating and to install clean heat technology in all 2.7 million housing association homes. This scale of funding is unaffordable within existing public budgets and the market has 'first-mover' concerns about whether savings can be achieved to meet repayments. While government has committed to grant funding a number of policy initiatives (HCLG Committee 2021), a new financial model for social housing retrofit is required that gives confidence to lenders and simplifies access to public grant, tax relief, loan guarantees and borrowing against future revenue and savings.

Secondly, the market is not ready for large scale retrofit programmes. There is an uneven distribution of construction firms across the UK with the capacity and technical expertise to carry out the net zero works needed. Also, businesses are wary of sudden changes in national policy that reduce certainty of funding, causing a reluctance among SMEs to invest in capacity ahead of explicit client demand. The construction sector has called for better strategic planning at a national level and support to accelerate the preparedness of firms to deliver net zero (CITB 2021). Similarly, there is a limited national supply chain in the manufacture and provision of net zero materials and technology. For example, a majority (68 per cent) of air source and ground source heat

Core Net Zero	Existing Skills	Updated Skills	New Skills
Heating replacement of gas heating systems	Plumbing and heating Gas installation HVAC Building services engineering Mechanical engineering	Air and ground heat sources and pump installation Refrigeration (heat pumps) Low temperature heating Groundwork / service pipes Electric boiler systems Plant system design	Whole house heat assessment Heat installation design Building Information Modelling Installation and use of smart meters
Insulation improved thermal efficiency of homes	Plastering Drylining Thermal Insulation Insulation and building treatments	Interna! insulation External insulation Passive fire protection Technical accuracy	Whole house heat assessment 30 digital measurement Off-site design of insulation
Fenestration reduce heat loss through doors and windows	Glazing, window and door fitting Carpentry and joinery Specialist fenestration	Thermal efficiency measures Technical accuracy	Whole house heat assessment Window and door unit design
Microgeneration installation and management of PV systems	Multi skilled Electrician Plumbing Roofing	Understanding of PV systems 1 nstall ation certification Updated health and safety	Installation and use of smart meters

Figure 1: Changing Skills Requirement for Net Zero

pumps used in the UK are imported (BEIS 2020). Significant sector and supply chain development is needed to enable the UK to operate at a scale to achieve the 2050 net zero housing targets.

Thirdly, the impact on labour and skills. The adoption of new standards and green construction techniques to build and retrofit housing has significant implications. While there are some new skills needed for net zero, in areas such as carbon assessment, retrofit co-ordination and heat pump installation, most demand will be met through the adaptation of existing skillsets. As shown in Figure 1, many of the new competences for net zero are aligned with 'traditional' construction trades and can be addressed through the targeted delivery of in-work short course training and integrated into vocational training curricula. The key challenge for the construction sector is the pace of transition to new and updated skills to meet anticipated demand and avoid shortages that will slow the ability of the sector to deliver housing retrofit at the needed scale.

While most elements of social housing retrofit are about physical improvements to properties, it is important to remember that achieving energy efficiency gains is a co-production between the landlord and the tenant. Ensuring that individuals understand both the goals of net zero and how to best manage energy use in the home is essential to realising the full environmental benefits of capital investment. Including tenant engagement, consultation and education into the delivery of retrofit schemes is vital to avoid significant under-performance of energy efficiency improvements.

3. London Borough of Camden Housing Retrofit

Camden is a central London borough, with a resident population of some 279,000 people in 2020. It forms a vibrant and major part of the London economy, with 34,000 businesses and 389,000 jobs. Despite the scale of economic activity, the borough has areas of significant deprivation, with around 15.3 per cent (one in six) of households workless, compared to 11.3 per cent for London (ONS 2020). Housing affordability is a major issue, with many people on low and medium incomes unable to meet the costs of private rents and house purchases. Even before recent rapid rises in energy prices, more than 10 per cent of homes in the borough were in fuel poverty (London Borough of Camden 2020).

Camden Council declared a climate emergency in November 2019. Camden's climate action plan estimates that the 33,000 properties within its social housing stock are responsible for around 10 per cent of the direct greenhouse gas emissions of the borough (ibid). Working with **Inner Circle Consultants**, the Council has developed a programme to retrofit its housing stock, deliver energy efficiency improvements that contribute to its net zero targets and use the capital expenditure to generate lasting employment, skills and economic opportunities for residents.

The key elements of the programme are as follows.

Building a Dynamic Programme

The first step to deliver a large-scale social housing retrofit programme is to mobilise existing data to create a detailed profile of the social housing stock. As most councils lack comprehensive use data, there may be an initial reliance on modelled data, which will need to be tested as the programme moves into delivery to accurately quantify costs and carbon savings. For Camden, building a dynamic programme involved the following:

- Assembling available base data on the condition and energy efficiency rating of all properties. Bringing together existing housing asset management information into an interactive database able to sort and prioritise properties for net zero investment.
- Creating a 'roadmap to retrofit' that provides indicative costs of delivery and establishes criteria to group and select homes for heating, insulation, glazing and microgeneration works.
- Establishing a timetable for batches of works (see figure 2) to determine funding sources and procurement requirements.

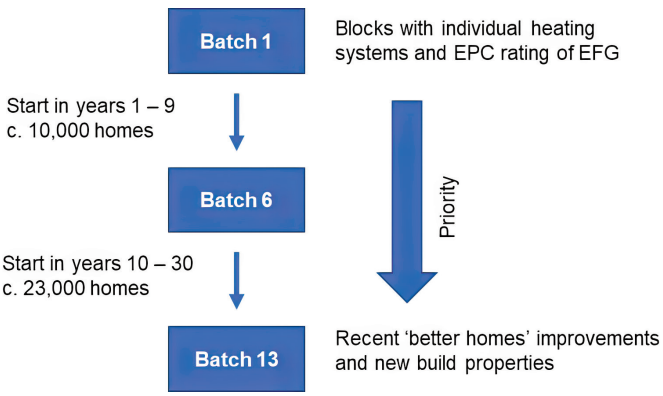

Figure 2: Delivery Across 13 Batches of Work

Refining Procurement Arrangements

Procurement arrangements must be fit to deliver the scale of works at the right quality, within a partnership approach to realise required local economic benefit outcomes. In Camden, the procurement arrangements were reviewed through the following actions.

- Testing the existing housing contractor frameworks for suitability against net zero delivery requirements. Identifying whether framework contractors had the scale, technical qualifications and capacity to deliver retrofit works.
- Determining how far employment, skills and local economic benefit outcomes are embedded in procurement assessment and contract delivery process. Improving procurement scoring criteria to give adequate weight to achievement of jobs and skills outputs through the delivery of net zero improvements.
- Building scale through partnerships with London councils and housing associations and strengthening relations with contractors and supply chain organisations to make a market for net zero.

Capturing Employment and Skills Benefits

To realise the full local benefit of capital investment, it is essential to develop a clear framework, at an early stage the contracting process, to ensure skills and economic outcomes. In Camden, data from the dynamic programme was used to define potential employment and qualifications outcomes that could be achieved by contractors, using the following steps:

- Breaking down the batches of work to estimate total workforce requirements, additional entry or training posts and labour replacement. This was refined to determine demand by skill types in relation to heating, insulation, glazing and microgeneration works – illustrated in figure 3.
- Identifying requirement for new and adapted skills among entry and existing workforce members to deliver high standard net zero installation.
- Aligning existing employment advice and training provision, such as the **Kings Cross Construction Training Centre**, to engage and support residents into jobs and training. Also including Camden's Direct Labour Organisation as a potential deliverer of net zero works to capture more local employment benefit, directly skill the workforce and accelerate access to supply.
- Discussion with colleges and training providers to identify existing capacity to meet skills demand and identify areas for curriculum development or capital investment in equipment and facilities.

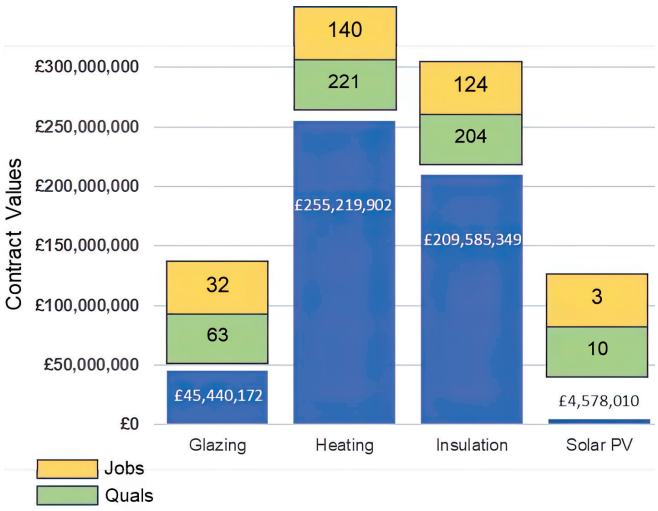

Figure 3: Additional Jobs and Qualifications Expected by Work Batch

Programme Governance

The size and timescale of the Camden retrofit programme underlined the importance of effective governance arrangements. Strong external partnerships with stakeholders are essential for all aspects of programme planning and delivery, as is cross-departmental working within the council. Social housing retrofit requires input from council housing, finance, economic development, education and environmental services that can be siloed within corporate structures. For the Camden net zero programme, arrangements included the following.

- Establishing internal governance and delivery structures, across the council, to create the capacity and resource needed to realise the net zero programme.
- Building external partnership groups to input into the development of the programme and support ongoing delivery. Key stakeholders included major contractors, colleges, the Greater London Authority and neighbouring councils.
- Focusing on community engagement to raise public awareness of the planned investment in housing and prepare residents for the works and the opportunities that would be generated by the net zero programme.

4. Policy Implications

Despite the ambitions for retrofit of social housing being relatively clear, the processes, preparation and market for delivery are immature, creating a lag in responsiveness affecting the construction sector skills and supply chain. Councils and housing associations have a vital role to play in driving the delivery of energy efficient social housing, but need stronger engagement by central government on issues of long-term affordable finance, mechanisms to accelerate skills transitions, green building standards and incentives to build a domestic supply chain in the materials and technology needed to deliver housing net zero.

There should be a clearer alignment of public policy to maximise the opportunity presented by social housing retrofit to not only achieve climate goals, but make a substantial contribution to post-Covid economic recovery and the Levelling Up agenda. Increasing the pace of devolution of skills and employment budgets to encourage the development of bespoke training and employment schemes targeting construction workers is vital to avoid skills shortages compounded by the loss of migrant labour in the sector.

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